INFERTILITY:

A GUIDE FOR PASTORAL CARE AND COUNSELING

by

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ABSTRACT

This is a counseling guide designed to prepare ministers and pastoral counselors to work more effectively with infertile persons and couples. The project has not attempted to deal extensively with any one aspect of infertility; rather, the intent has been to delineate the issues and the range of the experience so that infertility can be more readily identified and effectively addressed.

First, a broad understanding of infertility as it is interpreted in the Old Testament is necessary because simplistic and moralistic interpretations of this literature are deeply implicated in modern attitudes toward infertility which exacerbate feelings of social and religious estrangement. The texts are richly varied and complex, and an appreciation of the narratives and poetry based on an historico-critical understanding can help to replace oppressive biblical interpretations with liberating images and insight.

Attention is then directed to the New Testament and early church writings, where the social institutions of marriage and family did not go unchallenged. Because the social-theological bias of mainstream churches so heavily favors the nuclear family, infertile couples do not fit into the best-known model of Christian lifestyles. Recovering the historic voices of dissent in order to readjust current thinking concerning the role of the family as a Christian institution may be helpful in discerning possible responses to infertility.

A survey of the most common causes of infertility and treatments is presented. Theories concerning the role of psychological factors are

also discussed. This project works with the assumption that physical and mental health are closely related, and that disturbances of either area in an individual's or couple's life can drastically affect the other. Pastoral care can be an important factor in preventive mental and physical health; counseling can contribute to a couple's physical as well as emotional therapy.

Chapter VI then focuses upon the contrasting work of two ethicists--Paul Ramsey and Joseph Fletcher--in order to hold up the main lines of thought in the field of Christian ethics today as they relate specifically to infertility and its treatment.

Chapter VII explores some of the alternatives currently available for the couple for whom treatment is unsuccessful. The controversial but growing use of a surrogate mother, artificial insemination by a donor, adoption, and childfree living are discussed.

The final three chapters are an exploration of the psychological/emotional dynamics of infertility and their implications for counseling. The dynamics of crisis and grief are considered as they help to illuminate the infertility experience. Within that context, attention is then turned to the use of the counseling growth group for infertile couples.

Chapter I

INTRODUCTION

A. INTRODUCTION

More than six million couples in the United States suffer from infertility. A representative sample of congregations may show as many as one out of six couples of childbearing age unable to conceive. The experience of infertility is not primarily the experience of a medical problem, but the experience of emotional loss. How this loss is experienced, interpreted, and--hopefully--transcended by the couple has consequences for the total Christian community. The significance of the infertility experience lies not in whether the couple ever conceives, or gains a child by some other means, but in the interpretation given to the experience in the shared life of the couple and their faith community.

This project has been written out of the conviction that the Christian community has a vital role to play, not only in maintaining the emotional health of the infertile couple, but in shaping attitudes toward infertility, the nature of its treatments, and alternatives to the biological-nuclear family unit. The project has not attempted to deal extensively with any one aspect of infertility; rather, the intent has been to delineate the issues and the range of the infertility experience so that infertility can be more readily identified and effectively addressed.

B. METHOD

With this goal in mind, attention is turned first to a study of infertility as it functions as as both theme and metaphor in the Old Testament. Traditional interpretations of the well-known patriarchal narrative material have been broadly influential on two levels. First, Judeo-Christian communities have given the material a predominantly moralistic interpretation. In the context of these faith systems, infertility continues to be seen primarily as a punishment for sin, or at best a testing of faith. This interpretive stance, largely unchallenged on the basis of textual study, has led both to the rejection of the Old Testament as irrelevant for the interpretation of the infertility experience, and to the underlying conviction that infertility is more directly the result of divine intervention (or non-intervention) than other physical disorders.

Second, these narratives are an integral part of our cultural attitudes toward infertility. Attitudes based on the Old Testament literature which emphasize the blessing and duty of procreation, internalized in Western culture, are generally mistaken for purely "biological urges," or an individual's socialization by family, friends, and media. A broad understanding, not only of the patriarchal material, but other material as well, is necessary if oppressive biblical (and social) interpretations are to be replaced with liberating images and insight.

Attention then turns to the New Testament and the early church, where the social institutions of marriage and family did not go unchallenged. Because the social-theological bias of mainstream

churches in contemporary America so heavily favors the nuclear family structure, infertile couples (like unmarried, divorced, or widowed persons) do not fit into the best known models of Christian lifestyle. Recovering some of the church's historic voices of dissent in order to readjust our thinking concerning family and family units as Christian institutions may be helpful in discerning possible responses to infertility.

A discussion of the most common causes of infertility and their treatments has been included because any constructive personal or professional response to infertility demands a basic knowledge of what infertility is. An acquaintance with current theories concerning possible psychological factors is extremely important for the minister or counselor who attempts to define what his/her role should be in terms of the needs for care and/or counseling. This project works with the assumption that physical and mental health are closely related, and that disturbances of either area in a person's life can drastically affect the other. Pastoral care can be a factor in preventive mental and physical health; counseling can be a factor in physical as well as emotional therapy.

Ethical arguments concerning what constitutes justifiable treatment of infertility are rarely discussed, and yet infertile persons often have strong feelings as to what they feel is justifiable for themselves. The couple's decisions, while not ignoring deep-seated feelings and urges, need to also take into account standards beyond those feelings. "Ethics" does not refer to what is moral or not, but to the process of deciding whether an action is moral. Chapter five focuses

upon the contrasting work of two ethicists--Paul Ramsey and Joseph Fletcher--in order to hold up the main lines of thought in this field today as they relate specifically to infertility.

If medical treatment is unsuccessful, attention needs to be turned to alternatives. Chapter six attempts to define what these alternatives might be, and what difficulties--as well as possibilities--they pose.

The final three chapters are an exploration of the psychological/emotional dynamics and their implications for counseling. The discovery of infertility can precipitate an emotional crisis, occasionally of major proportions. However, whether crisis results or not, all persons who want a baby go through a grief process. The dynamics of crisis and grief are considered as they help to explain the infertility experience. The emotional behaviors associated with grief and crisis are adaptive responses to emotional trauma, pathological only if their emotional resolution is blocked. Within that context, attention is then turned to the use of the growth and fellowship group for the treatment and support of infertile couples.

The project has not attempted to deal extensively with any one aspect of infertility; rather, the intent has been to delineate the issues and the range of the infertility experience so that infertility can be more reeadily identified and effectively addressed. Although it has been written primarily for ministers and pastoral counselors, it is hoped that anyone interested in the wholeness of persons confronting infertility will find it helpful.

C. DEFINITION OF TERMS

"Infertility" is a descriptive rather than diagnostic term. It refers to the temporary or permanent inability of a couple to conceive a pregnancy, or to carry it to a live birth. According to the American Fertility Society, any couple who engage in random, unprotected intercourse for a year without a conception are infertile. Infertility can indicate a serious health threat (for example, if it results from a uterine or glandular tumor), but if not, medical treatment is required only if a pregnancy is desired. Infertility is not synonymous with childlessness, since a couple may have one or two children born to them, and then discover to their surprise that they are having trouble conceiving another. "Infertility" is synonymous with "barrenness" and "sterility," but these terms have generally fallen into disuse because of their negative connotations.

"The infertile couple" refers to a man and woman of childbearing age who are unable to conceive and carry a pregnancy. Phrases such as "the infertile wife" or "the infertile husband" are avoided because they obscure the fact that the couple is an interacting system. The medical problem sometimes belongs to only one partner, but the infertility experience is always an experience for both. The dimensions of the emotional experience are always interpersonal.

Infertility may be a problem for a single person, as well as for one married or living with a life partner. For example, a man who discovers after a serious illness or accident that his sperm count is so low he will probably never be able to father a child may have intense feelings of loss. It is also not uncommon for a single woman to request

artificial insemination and/or infertility treatments because she wants to experience pregnancy, birth, and the raising of a child, and she sees no reason why that has to be dependent upon whether a man has offered marriage.

Finally, "pastoral care" includes all the church and community resources that a minister utilizes to meet the educational, social, and faith needs of persons in his/her parish. "Counseling" refers specifically to the use of tools and methods such as the small group, and the interview session. As used in this project, counseling refers primarily to "pastoral counseling," that is, counseling undertaken by ministers or professional counselors who work within the context of a Christian community and under its authority.[1]

Chapter II

INFERTILITY IN THE OLD TESTAMENT

A. INTRODUCTION

Western attitudes toward birth and childbearing have been deeply influenced by the Judeo-Christian traditions. This chapter examines attitudes toward, and interpretations of, human fertility and infertility in the Old Testament. Because the biblical narrative and metaphoric images have a powerful influence upon our attitudes toward infertility, it is necessary to examine these narrative traditions and the poetic images more closely. The biblical traditions are rich and complex and reveal a profound appreciation of the tenuous process of conception and birth. They proclaim the wholeness of life in the name of the God who both gives and sustains all life.

B. THE SOCIAL CONTEXT

Survival in ancient Israel was precarious. Periods of constant hostilities, famine, infections, and disease made life a relatively short experience for all too many people. John Otwell points out that the infant and maternal mortality rate must have been extremely high, for despite an impressive total of eighty-eight children, II Chronicles 11:21 reports that King Rehoboam's wives and consorts bore an average of only 1.13 children each. Similarly, King Abijah's household, with fourteen wives, claimed thirty-eight children, an average of only 2.7 children for each wife.[1]

In such a setting childbearing was primarily a social rather than an individual function. The whole society gave reproduction high priority. Children were more than joy to their parents, more than security in old age; they were the fragile link between the nation's often tenuous present and its promised destiny.

The importance placed upon children appears throughout the Old Testament texts. A Wisdom Psalm describes the blessings of the righteous man:

> Your wife will be like a fruitful vine
> within your house;
> Your children will be like olive shoots
> around your table.
> (Ps. 128:3)

The psalm concludes with the benediction, "May you see your children's children! Peace be upon Israel!"

An Isaiah passage declares that the reward to the faithful will be so great that not even a eunuch need regret the lack of offspring:

> . . . let not the eunuch say,
> "Behold, I am a dry tree."
> For thus says the Lord:
> "To the eunuchs who keep my sabbaths,
> who choose the things that please me
> and hold fast my covenant,
> I will give in my house and within my walls
> a monument and a name
> better than sons and daughters;
> I will give them an everlasting name
> which shall not be cut off."
> (Is. 56:3c-5)

In both the psalm and the Isaiah passage, divine reward is measured by sons and daughters. This Isaiah oracle, far from dismissing the importance of offspring, affirms the great value of sons and daughters by boldly announcing that there will be <u>even</u> <u>more</u> possible

than this for those who are faithful and obedient.

C. THE LAW OF THE LEVIRATE

The practice of the Levirate recorded in Deuteronomy bears witness to the importance of a wife who could deliver sons for her husband. The Levirate forbade a widow with no son to be married off outside her husband's family. Instead, the husband's brother was required to take her as a wife until she gave birth to a son, who then succeeded to the name and the property of the dead brother. Should the living brother refuse, the wife took her complaint to the city elders. If he refused to obey even the elders, the wife publicly insulted him:

> . . . then his brother's wife shall go up to him in the presence of the elders, and pull his sandal off his foot, and spit in his face; and she shall answer and say, "So shall it be done to the man who does not build up his brother's house." (Dt. 25:5-9)

Two narratives are based on the Law of the Levirate. The first, the story of Tamar (Gen. 38:6-26), follows the Deuteronomy practice very closely. Judah took Tamar to be a wife for his first-born son, Er. But Er was wicked and the Lord slew him. Judah directed his second son, Onan, to go in to Tamar and raise up a son for Er. Onan, knowing that a son would inherit Er's property, spilled his semen on the ground to avoid getting Tamar pregnant. This displeased the Lord, and the Lord slew Onan also. Judah, perhaps afraid that Tamar possessed some sinister power which had caused his two sons to die, told her to return to her father's house until his third son, Shelah, was old enough to perform his duty as brother-in-law.

But Shelah grew, and Tamar was not given to him. When the opportunity came, she disguised herself as a prostitute and tricked her father-in-law, Judah, into having intercourse with her, demanding his signature stamp, cord, and staff in pledge until he sent payment. Later, when Judah sent payment to redeem his pledge items, the "prostitute" could not be found.

In about three months, word came to Judah that Tamar was pregnant. As her father-in-law, Judah ordered her to be burned, but as she was being brought she sent the pledge items to Judah with the message, "By the man to whom these belong, I am with child." Judah immediately declared that Tamar was more righteous than he, because he had refused her his son Shelah. The narrator's approval of Tamar's extreme action is unqualified: she gave birth to twin sons, both critical to the lineage of the nation.

The second narrative which depends upon the Law of the Levirate is the Book of Ruth. This narrative, however, deviates in a number of ways from the pattern found in Deuteronomy, either because the narrative situtation is more complicated, or because it represents several different stages in the Hebrew practice. For example, the exchange of the sandal in Ruth 4:7 is not the insult specified in Deuteronomy, but a contract between Boaz and Ruth's kinsman. Still, two elements clearly reflect the Levirate. First, the rich man Boaz is able to take the widow Ruth for his wife only after the man who is her husband's next of kin gives up his rights to her--or, more accurately, his duty to her husband. The next of kin is willing to do this because if Ruth had borne a son by him it would have endangered his own son's inheritance.

Second, although Naomi was the mother of Ruth's husband and no relation to Boaz, the Levirate is implicated when Ruth gives birth and the women of the city announce, "A son has been born to Naomi."

D. THE IMPORTANCE OF SONS

Sons were vitally important to men because a man's status and prestige depended upon them. Only the man with many sons could be sure that his voice would be heard in council as the head of the extended family or clan. A man's political strength was in direct proportion to the number of males he could count upon for unswerving loyalty in council as well as in combat.[2] And, because the Hebrews had no belief in an afterlife, children provided the only possible immortality. Sons inherited the name and the property of the father, and in this way the father continued to live on after his death.

The wife who bore sons commanded the respect of her husband and his family. Jacob's less-favored but more fertile wife Leah hoped that sons would gain his favor. Her sons' names reflect her hope. Reuben--"Because the Lord has looked upon my affliction; surely now my husband will love me." Simeon--"Because the Lord has heard that I am hated, he has given me this son also." Levi--"Now this time my husband will be joined to me, because I have borne him three sons . . ." (Gen. 29:32-34).

Women also respected the mothers of sons. In Genesis 35:17, the midwife encourages Rachel, dying in childbirth, saying, "Fear not, for now you will have another son." Likewise, the women in Ruth 4:15 congratulate Naomi on the birth of her grandson with the acclamation

that he will be "a restorer of life and a nourisher of your old age."

The importance of sons can be measured in the severity of their loss. Before hewing the captive King Agag in pieces, Samuel declares, "As your sword has made women childless, so shall your mother be childless among women" (I Sam. 15:33). In II Samuel the wise widow of Tekoa petitions King David for the life of her son. She tells the king that during the heat of an argument, one son killed his brother, and the people demand the death of the killer, the remaining son. The widow pleads,

> and so they would destroy the heir also. Thus they would quench my coal which is left, and leave to my husband neither name nor remnant upon the face of the earth. (II Sam. 14b)

Her argument sways the king; for the sake of the widow and her husband's name, the son will not be executed. The loss of the widow's social and economic security, and the husband's name and memory would be more serious than the crime which had been committed![3]

And yet, while sons were more valued, pregnancy was greatly desired regardless of the sex of the child. When Hagar conceived by Abraham, she looked with contempt on her mistress Sarah (Gen. 16:4). Rachel provoked her husband Jacob to anger when she cried out bitterly, "Give me children or I shall die!" (Gen. 30:1).[4] Offspring, male or female, were so important that a man was exempted from military duty for a year until he had an opportunity to beget a child (Dt. 24:5).

E. THE UNDERSTANDING OF CONCEPTION

The Israelites understood the general function of male semen; the necessity of a man's participation to achieve a pregnancy was clear

(cf. Is. 8:3; II Sam. 11:4f; Gen. 38:9). What they did not understand was the growth of the fetus. For them, the mystery of pregnancy's progress and the growth of the fetus was clearly analogous to the mystery of God's creative work:

> As you do not know how the spirit comes to the bones in the womb of a woman with child, so you do not know the work of God who makes everything. (Ec. 11:5)

The ancient Israelites also knew the limits of normal expectations. Sarah and Abraham laughed when they were told Sarah would have a son, for she was ninety years old, and Abraham a hundred (Gen. 18:17). The woman of Shunem had an old husband, and when the prophet Elisha told her she would give birth, she responded, "No, my lord, O man of God, do not lie to your maidservant" (II Kings 4:16). That aged men and women give birth in these ancient narratives does not display a primitive naivete regarding the birth process. Rather, the couple's age underscores the magnitude of God's gracious intervention and allows the hearer to answer the question posed to Abraham: "Is anything too hard for the Lord?" (Gen. 18:14).

F. YAHWEH'S PARTICIPATION IN CONCEPTION AND BIRTH

Conception and the growth of a fetus were attributed directly to divine activity. The Deuteronomic law code promised that "there shall not be male nor female barren among you, or among your cattle" (Dt. 7:14b) if the nation would be faithful to Yahweh's covenant. Since Deuteronomy viewed Israel's history in retrospect, one must conclude that barrenness of crops, herds, and humans was a fact of life, a fact the Deuteronomic writers explained by the reality of the people's

individual and collective disobedience throughout the years since Moses. Some explicitly regarded children as God's reward for piety, and barrenness as punishment for sin. This attitude, which will be discussed further in this section, is not found throughout the Old Testament, however.[5]

The traditions are unified in their belief that the womb belongs to God. Only Yahweh could close or open wombs. In the account of Sarah in the house of King Abimalech, Yahweh closes every womb in the household until Sarah safely returns to Abraham--and then opens the wombs once more for fertility (Gen. 20:1-18).

In the Jacob narrative, Laban used his daughter Leah to trick Jacob into working as a free laborer years beyond their original agreed time. Jacob was forced to accept Leah as his wife, but "when Yahweh saw that Leah was hated, he opened her womb" (Gen. 29:31). The rejected Leah's position as wife was secured with the birth of four sons. The wife Jacob loved, Rachel, bore none during this time, but there is no indication that Rachel was being punished, only that Leah was being blessed. Later "God remembered Rachel, and God hearkened to her and opened her womb" (Gen. 30:22).[6]

Although wombs might be closed in judgment, the fact of a closed womb did not necessarily indicate God's punishment. The narrative traditions have little interest in <u>why</u> a woman was barren; they are far more interested in the fact that conception occurred because of God's intervention when all human hope was gone. Even Sarah's admission that Yahweh had prevented her from having children (Gen. 16:2) in context seems to be little more than a flat statement that she had not borne

children, and would not. Her righteousness or deserving is never at issue. Similarly, no reason is given for the barrenness of Rachel, Leah (who stopped bearing for a time), or Hannah. In each case, the phrase "God remembered" appears before a barren womb is opened in conception, emphasizing the immediacy of God's participation in the event.

Barrenness is also attributed to sin, however. For example, Michal and David have a bitter argument after he dances before the Ark of the Lord. The narrator closes the incident with the comment that Michal was childless to her death (II Sam. 6:20-23). Barrenness was also connected to national sin, especially as the result of idolotry:

> Ephraim's glory shall fly away like a bird--
> no birth, no pregnancy, no conception!
> Even if they bring up children,
> I will bereave them till none is left.
> . . . .
> Give them, O Lord--
> what wilt thou give?
> Give them a miscarrying womb and dry breasts.
> (Hos. 9:11-12)

Because conception and birth were regarded as creative and salvific acts of God, actions which disrupted reproduction were sins punished by death. The Lord slew Judah's son Onan because he spilled his semen on the ground. Likewise, the prophet Amos pronounced judgment against the Ammonites:

> because they have ripped up women
> with child in Gilead,
> that they might enlarge their border.
> (Am. 1:13b)

The womb was singled out for divine protection, but so were the male sex organs. An exceptionally harsh law arose out of the belief that the male spring of fertility should not be blemished or

endangered:

> When men fight with one another, and the wife of the one draws near to rescue her husband from the hand of him who is beating him, and puts out her hand and seizes him by the private parts, then you shall cut off her hand; your eye shall have no pity. (Dt. 26:11)

G. THE METAPHOR OF CONCEPTION

In the mind of an ancient Israelite, no child could be born without God's participation. The birth of a child was a sign of God's presence among the people. The prophets Hosea and Isaiah, for example, gave their sons and daughters names which were part of their message. Hosea gave two of his children the ominous names, "Not Pitied," and "Not My People," but when the prophet's message changed from judgement and warning to comfort and reconciliation, their names were changed to "She Has Obtained Pity" and "My People."

Old Testament scholar Phyllis Trible points out that because God's role in bringing forth children from the womb was clear and direct, conception and birth became a metaphor for God's creative care, love, and presence among the people. The concept appears in personal psalms which pray for deliverance from illness for enemies:

> Yet thou art he who took me from
> the womb;
> thou didst keep me safe upon my mother's breasts.
> Upon thee was I cast from my birth,
> and since my mother bore me thou
> hast been my God.
> Be not far from me,
> for trouble is near
> and there is none to help.
>
> (Ps. 22:9-11)

It also appears as a metaphor for God's protection for the nation:

But now hear, O Jacob my servant,
Israel whom I have chosen!
Thus says the Lord who made you,
who formed you from the womb
and will help you . . .

(Isa. 44:1f)

Hearken to me, O house of Jacob,
all the remnant of the house of Israel,
who have been borne by me from your birth,
carried from the womb;
even to your old age I am He,
and to gray hairs I will carry you.
I have made, and I will bear;
I will carry, and will save.

(Isa. 46:3-4)

The metaphor carries the pronouncement of God's absolute sovereignty in dealings with the nation:

Woe to him who says to a father,
"What are you begetting?"
or to a woman, "With what are you in travail?"
Thus says the Lord,
the Holy One of Israel and his Maker:
"Will you question me about my children,
or command me concerning the work of my hands?

(Isa. 45:10-11)

H. THE PATRIARCHAL NARRATIVES

The patriarchal narratives are found in Genesis. They are the stories of Abraham, Isaac, Jacob (Israel), and Jacob's sons. The narratives appear in duplicate, sometimes even triplicate form, indicating several oral or written sources for the final form. The narratives refer to the patriarchs and their wives as historical persons, rather than mythical figures. Originally the patriarchs probably were not related. However, in the movement toward a unified nation the various tribes began to evolve a common history, and one of the ways this was done was to create one family tree out of several

traditions. The tribal groups which were dominant dominated the history. Thus Abraham gradually became the father of all of the patriarchs, and Isaac took his place as the son and sole heir of Abraham.

The final written narratives which have come to us today must be seen as retrospective, interpretive histories compiled with the conscious intention of interpreting the meaning of the "editor's" present political and social situation as much as carrying on the "factual" history of the distant past. The patriarchal history is a record infused with the awareness that Israel's beginnings were tentative, awkward, and all-too vulnerable. God's blessing upon the solitary, nomadic, and not always obedient Abraham, and the impossible promise of a mighty people in a secure land dramatize the divine scheme carried out against human odds. The final form which we find today in Genesis was edited and compiled in the time of King David, when the people were indeed mighty and the land of Israel was more united and secure than it would ever again be.

It is significant, therefore, that, either in the separate devolopment of the tribes' histories, or in the later development of the national history, the matriarchs are all barren. Sarah, Rachel, Leah, Rebekah--these are not just any barren women, but women who eventually gave birth to mighty tribes. Their barrenness has primarily a theological rather than historical significance because it powerfully depicts "history that almost didn't happen." Both the history and the ancient theology reflected in Genesis taught that Israel's origins were fragile. Israel's greatness was not due to its own resources, but to

the special intervention and promise of Yahweh.

Whether the patriarchs and matriarchs were historically "real" or whether the traditions evolved character composites of tribal founders and leaders whose names and personal histories were lost by assimilation cannot be historically verified. What is clear is the theological significance of the patriarchal history for the later people of Israel. The history is not concerned with Sarah's barrenness for historical interest as the first known barren woman, but because of the threat her barrenness posed for the promise given Abraham that he would be father of a mighty nation through Sarah. Her barrenness is only one of many obstacles, each one of which could easily destroy the promised line. The theme of the endangered line occurs throughout the patriarchal narratives and is continued, transformed, in the prophetic literature when the nation is reminded again and again that God has formed it and by God's action alone it is saved or destroyed.

I. THE BARREN MATRIARCHS

Except for Leah, who had six sons and one daughter, the matriarchs each bore only one or two sons. Sarah bore the long-promised Isaac in old age; Rebekah bore the twins Esau and Jacob only after Isaac entreated the Lord for her; and Rachel gave birth to Joseph and Benjamin. Even the handmaids given by these women to their husbands to produce children were limited in fertility. Sarah's maid Hagar had only one son, Ishmael, while Leah's and Rachel's maids were limited to two each. More will be said in a following section concerning these handmaids. At any rate, the conceptions of the matriarchs ensured not

simply their own satisfaction and security, but the future of Israel's divine promise.

Among the barren matriarchs, none is more humanly compelling than Rachel. Constrained to see her older sister give birth to four sons, she explodes to Jacob their husband, "Give me children, or I shall die!" Rachel's cry becomes the cry of both the barren and the bereaved. As the barren Rachel she weeps for her children "because they are not." Much later, when the people are led off into bondage and exile, the prophet Jeremiah reappropriate Ruth's lament: the mother of all Israel, once again childless, weeps for her children "because they are not," or, "because they are no more" (Jer. 31:15). Grief for the unconceived and grief for the dead (or defeated) are closely linked in Scripture.

J. THE WOMAN'S RESPONSE

In ancient times a barren woman apparently would undertake any course of action which might help her to conceive. Rachel gave her sister and rival wife Leah permission to sleep with Jacob in return for mandrakes [7] gathered by Leah's son Reuben. She conceived soon after (as did Leah!). The narrator is careful to state that Rachel conceived when "God remembered her," and no further connection is made with the mandrakes.

Hannah, the mother of the prophet Samuel (I Sam. 1:11), and Samson's mother (Judges 13:2ff) both took religious vows in order to conceive. Hannah promised that if the Lord remembered her with a son, she would give him to the service of the Lord as soon as he was weaned. Surprisingly, Hannah is the only woman portrayed in the Old Testament

praying for a child.

An angel of the Lord appeared to Samson's mother (who is never named) and told her she would bear a son. "Therefore beware, and drink no wine or strong drink, and eat nothing unclean . . . No razor shall come upon his head." Presumably she submitted to these directions.

But the most striking practice, which appears only in the patriarchal narratives of Genesis, was the custom of providing the husband with the wife's handmaid. The barren wife could give her servant or slave to her husband to take as a wife. Sarah, Rachel, and Leah all made such use of their maids. The maids' historical roles were considered important enough that the narrative histories preserved their names.

Contrary to today's popular interpretation, the primary reason for giving the handmaid to the husband was not necessarily for him to have a son. Abraham had already had children by other women when Sarah gave him Hagar. Nor was the need always to produce an heir. Jacob had had four sons by Leah when Rachel gave him Bilhah; and he had had four sons by Leah when Leah herself gave the maid Zilpah to him. Furthermore, the husband was free to take another wife, especially if his current wife was barren. Thus the practice has to have been for the wife's protection and benefit as well as for the husband's.[8] Since, in the Jacob narratives, a woman seems to have been given a handmaid as part of her dowry, one wonders if perhaps this was insurance for the bride; should she be barren, her position could be made secure through her maid's children which she would take as her own.

The handmaid apparently served two functions. First, she provided the wife with a child. The child born to the maid by the husband was regarded legally as the wife's child. Whether or not the child was the only heir in the household, the woman with an adopted child was assured of her right to stay in the household.

Adoption of a handmaid's children was fairly widespread throughout the Middle East in ancient times. An Egyptian document from about 1100 B.C. contains two legal records of adoption which describe this custom. The document is clear that the children of the slave, in this case bought by both the husband and the wife, were considered the children of the wife. All these adopted children were freemen, legitimate heirs of the husband's estate and protection. They were considered primarily the wife's sons and daughters and through her they had their rights.[9]

The Code of Hammurabi and a number of marriage laws and contracts from Mesopotamia deal with the giving of a maid or slave by a childless wife to her husband, and the subsequent treatment of such a slave girl by her mistress. Excessive abuse was forbidden, although the slave could lose her status as secondary wife if she attempted to put herself above her mistress, as Hagar did. Children of the slave were to inherit equally with any children subsequently born.[10]

The second function, according to anthropologist Raphael Patai, was to cure the wife's infertility.[11] The handmaid's fertility may have been thought to be beneficial to the barren wife. Patai maintains that the phrase "born on the knees" refers to the actual birth process in which the handmaid or slave in labor gave birth kneeling on the barren

wife's knees or lap. Symbolically the wife experienced the labor and the birth. The powers of the fertile woman were believed to be transferred to the infertile woman through bodily contact. Even up to recent times a variety of practices (not mentioned in Scripture) were followed in the Middle East, including bathing a barren woman in the water used to wash the clothes worn by a woman during her labor and birth, or seating a barren woman upon a birthing stool immediately after its use.[12] However, one must be cautious in deriving biblical customs from later customs. The practice of a servant giving birth on the knees of the infertile wife may have grown out of a particularly literalist interpretation and application of the scripture later, and not reflect the actual biblical practice at all. An idiomatic phrase which meant simply to be adopted probably was later interpreted literally and applied as a cure for infertility. Genesis 50:23 states that "the children also of Machir the son of Manasseh were born upon Joseph's knees," so it is highly unlikely that the phrase referred to the actual birthing process as Patai contends!

K. SIN AND CHILDLESSNESS

Sometime around the Seventh Century B.C. Israel's theology began to explicitly link sin with calamity. Sin was seen to be the direct cause of adversity. Since the punishment fit the crime, the nature of the misfortune itself provided a clue to the sin. Unintentional as well as intentional sexual sin could prevent conception or a live birth. Even unwitting adultery resulted in infertility; thus King Abimalech's horror at discovering he has another man's wife in his household is

understandable. Several versions of the Abimalech story appear: two involve Sarah in a king or pharaoh's household, the other, which scholars believe to be the oldest story of the three, Rebekah posing as Jacob's sister (Gen. 12:17, 20:17-18, 26:6-10).

Sexual sins were an abomination against Yahweh, probably because they were almost always connected to the worship of foreign gods. The rulings on forbidden sexual relations are prefaced, "You shall not do as they do in the land of Egypt, where you dwelt, and you shall not do as they do in the land of Canaan, to which I am bringing you" (Lev. 18:3). Idolotry and sexual perversions seem to have gone together, for the prohibition of child sacrifice to the Ammonite deity Molech, and of human-animal sexual relations are right in the middle of the list which ennumerates when and with whom intercourse is an abomination (Lev. 18:21, 23).

Leviticus warns that if a man and the wife of his uncle or his brother lie together, both shall "bear their sin" and die childless (Lev. 20:20-21). However, childlessness did not necessarily mean infertility in this case; presumably if children were born they would die before the parents.

The punishment for sexual sins was death. The declaration of childlessness was a deferred, but irreversible death sentence, ultimately no less severe than immediate execution. In the Book of Job, for example, Job asserts his righteousness in a series of sixteen oaths. In 31:9-12, he declares he is innocent of adultery, "For that would be a heinous crime . . . and would burn to the root all my increase." "Increase" here refers to his children. The adulterer dies childless.

Although adultery or perversion is not listed, the speech of Job's neighbor, Bildad the Shunamite, reflects this dominant sin-misfortune theology. The wicked faces sure and total destruction:

> His roots dry up beneath,
> and his branches wither above.
> His memory perishes from the earth,
> and he has no name in the street.
> He is thrust from light into darkness,
> and driven out of the world.
> He has no offspring or descendant among his people,
> and no survivor where he used to live.
> (Job 18:16-19)

Adultery and sexual perversions caused sterility, but apparently so could idolotry. The reward for national faithfulness to the Lord's Covenant included not only sufficient food and water and military victories, but the promise that "none shall cast her young (miscarry) or be barren in your land" (Ex. 23:26). Miscarriage, famine, draught, and military defeat which meant massive extermination were bitter realities, attributed to national failure to observe the Covenant.

So important was fertility that the trial for a wife suspected of adultery is the only example in the Bible of ordeal proceedings. The description of the Sotah appears in Numbers 5:11-31. Second Century A.D. Talmudic scholars interpreted the line, "But if the woman has not defiled herself and is clean, then she shall be free and shall conceive children," to mean that an accused woman who had been barren would become fertile and conceive. However, the famous Rabbi Ishmael protested against this majority opinion, saying that in that case the Sotah would be used to cure sterility. All a barren woman would have to do would be to hide from her husband, be accused, tried and vindicated, and then bear her child. Rabbi Ishmael refused to accept this

conclusion. Still, the rabbis ruled that women beyond the age of childbearing, or who were physically incapable of bearing children could not be subjected to the Sotah.[13]

L. THE SHAME OF INFERTILITY

Within the Old Testament context it is clear that the woman bore the blame for failure to conceive. The Hebrew word herpah is usually translated as shame or reproach for the barren woman, as for example, "take away my reproach," or "remove my shame from among men." The word has a wider word field than the English word shame indicates, however. It does not primarily indicate personal shame, but a social position, as in "I am the scorn of all my adversaries," or "we are the taunt of our neighbors." Herpah is a disgrace done to one, and so one bears it whether or not one has done anything to deserve it. Humiliation, to be subject to insolence, real shame, frustration, bitterness, disappointment--all of these are part of the meaning of herpah. It was not primarily the reproach of the Lord which the women bore in these Scriptures, but the reproach of men and other women. Their conceptions in each case turned personal humiliation into great joy, and thus barrenness functions as a receptacle for divine initiative and grace.[14]

M. CONCLUSION

It has been seen that the biblical texts are richly varied in their interpretation of infertility. The patriarchal narratives have been explored with an eye to their theological purpose rather than their

historical accuracy. It was seen that the images of fertility and infertility became powerful images for God's love, care and sustenance--or judgment.

A solid grounding in the Old Testament's theological interpretations of infertility is helpful in understanding and addressing the contemporary problem for several reasons. First, moralistic and simplistic interpretations of the patriarchal narratives are deeply implicated in modern attitudes toward infertility, attitudes which exacerbate feelings of guilt, loss, judgment, social and religious estrangement, and personal worthlessness. An appreciation of the narratives and poetry based on a historico-critical understanding can enable the reader to draw analogies to our own time and understanding, and to replace the moralistic interpretations ("If you have faith, you'll have a baby just like Sarah") with liberating theological and personal insight.

Chapter III

EARLY CHRISTIAN OPPOSITION TO THE FAMILY

A. INTRODUCTION

Mainline American churches are undeniably pro-family. The eagerness with which a new family is received into a congregation, the satisfaction the congregation feels when the children's Sunday School classes are growing, the rose on the altar for the safe birth of a son or daughter or grandchild--each of these indicates the importance congregations place upon the families among them. Although planning committees try not to exclude anyone from participation, it is often clear that Family Night in the Refectory really is an evening for the church's nuclear families. Like single parents, singles, and elderly persons who may feel out of place, infertile couples are constantly reminded of their childless status.

One of the self-perceived duties of the church is to strengthen the family institution. In addition to social and theological supports, there are strong scriptural and historical bases for a pro-family orientation. The family is one expression of the Christian nurturing community which exists to encourage each individual to reach his/her fullest potential, and to assist each toward complete personhood.[1]

But if one can point to the scriptures and traditions of Christianity for pro-family supports, one can just as easily find traditions which either deny family claims or radically relativize them. If congregations are going to do more than "rubber stamp" cultural

values and secular trends, they must become aware of their historical and theological roots.

Early Christianity had two streams of thought regarding marriage and family. The one which became dominant in western Christianity supports the family as the basic unit of the Christian body; the other demands that family claims be renounced in order to give oneself to a life of prayer and contemplation, or prayer and social service. It is this second stream, an ancient Christian critique of marriage and procreation, to which this paper now turns. The voices for the Christian family have a wide hearing and a strong influence in the churches and the population at large. By no means does this project expect celibacy to become a viable alternative for infertile couples! Nor is the intent to denigrate the strengths of the family unit. But for those who are either voluntarily or involuntarily childless, the dominance of the pro-family voices have supported rather than countered external as well as internal pressures to have a baby. They have served to block the Good News the Church is commissioned to proclaim and to embody for those left outside family settings, as well as for those inside nurturing family structures. It may be helpful to recover some of these dissenting voices in order to set these values of marriage and family into a broader Christian perspective.

B. THE TEACHINGS OF JESUS

While the Gospels record the stories of Jesus taking little children and blessing them, and turning water into wine at the marriage at Caana, (thus yielding the one Gospel passage which is interpreted as

Christ's blessing the institution of marriage), the overwhelming witness is to a drastic renunciation of the importance Jesus' culture placed upon marriage and the birthing of children.

In all his dealings with women, nowhere does Jesus give advice concerning marital matters. Frequent hosts of Jesus and his disciples, the sisters Mary and Martha are never encouraged to marry, and if they were married, their husbands are never mentioned. Jesus declares to the woman of Samaria that she has been married five times. Her response is to publicly declare her belief in him as the Messiah. How her belief affects her relationship with men so far as marriage is concerned is not revealed (John 4:7-42).

Women receive healing at Jesus' hands, but no example of a woman healed in order to bear children can be found in the Gospels. This is startling, in light of women's role in the Near Eastern world of the first century where bearing children remained a woman's prime function and her path to social respect. The suggestion that there were no infertile women cannot be seriously entertained. Instead, Jesus clearly rebukes such values.[2] For example, in grateful response to Jesus' teaching, a woman cries out a traditional blessing to him: "Blessed is the womb that bore you, and the breasts that you sucked!" His response must have stunned her and those about her: "Blessed rather are those who hear the word of God and keep it!" (Luke 11:27-28).

Some New Testament scholars suspect that Jesus' relations with his own family were strained.[3] They point to Gospel passages which, if they do not indicate familial hostility, definitely do indicate a radical relativizing of the family household bond Jesus' culture and

religion demanded.

> For I have come to set a man against his father, and a daughter against her mother, and a daughter-in-law against her mother, and a daughter-in-law against her mother-in-law; and a man's foes will be those of his own household. He who loves father or mother more than me is not worthy of me; and he who does not take his cross and follow me is not worthy of me. (Mt. 10:35-38)

> And his mother and his brothers came; and standing outside they sent to him and called him. And a crowd was sitting about him; and they said to him, "Your mother and your brothers are outside, asking for you." And he replied, "Who are my mother and my brothers?" And looking around on those who sat about him, he said, "Here are my mother and my brothers! Whoever does the will of God is my brother, and sister, and mother. (Mark 3:31-35; see also Mt. 12:46-49)

Whatever the historical relationship between Jesus and his family, it is clear that Jesus' teachings challenged the dominant cultural values concerning marriage and family, and these teachings were carried on in the life of the early Church.

C. THE TEACHINGS OF PAUL

Paul's orientation toward marriage and family is closely alligned with Jesus' teachings as recorded in the Gospels. Paul, like Jesus, believed that the end of the present order was imminent. Therefore there was no need to continue to marry and to reproduce. Marriage is no sin if passions are running strong--let the couple marry, Paul declares (I Cor. 7:9,36). Still, it is better not to marry, because only the unmarried have the freedom from familial responsibilities to devote themselves wholly to heavenly matters.

> I want you to be free from anxieties. The unmarried man is anxious about the affairs of the Lord, how to please the Lord; but the married man is anxious about worldly affairs, how to please his wife, and his interests are divided. And the unmarried woman or girl is anxious about the affairs of the Lord, how to be holy in body and spirit; but the married woman is anxious about worldly

> affairs, how to please her husband. I say this for your own benefit, not to lay any restraint upon you, but to promote good order and to secure your undivided devotion to the Lord. (I Corinthians 8:32-35)

Clearly, Paul prefers celibacy.

For those who are married, Paul makes no reference to the birth of children. Current Jewish teaching held that after ten years of barren marriage, divorce was not only the man's right, but his duty. Procreation was the essential justification of marriage.[4] A barren marriage was not reason for divorce in the early Christian communities, however, because procreation was no longer regarded as of primary importance: "the apportioned time has grown very short" (I Cor. 7:29). For Paul, marriage's justification is its protection against sexual immorality (I Cor. 7:2). The desire for children does not justify the sexual encounter. Woman is no longer a medium through which man reproduces himself in order to live on in a son; nor is man the means for a woman to be fulfilled in motherhood. The husband rules over his wife's body; the wife rules over her husband's body (I Cor. 7:4). They are to live in mutual submission and agreement. Von Allmen, discussing Pauline attitudes, writes that the woman is to find fulfillment in her husband rather than in her children, and the man finds fulfillment in his wife rather than his children or his parents.[5] It is true that children are not the source of fulfillment for the couple, but von Allmen's interpretation goes astray, largely because he is attempting to construct a Biblical base for contemporary forms of marriage. Paul is quite consistent in his belief that meaning and fulfillment are found in the Lord rather than in one's spouse. Paul's preference is that, if one were a husband when called by God, one remain a husband; if a wife,

remain a wife. If one were unmarried, then remain unmarried. The sanctity of marriage is clearly subordinated to the demands of baptism. Marriage and the bearing of children are firmly bound up in the present order, which is coming to a close. In the new order, there will be no place for the bondage of anxiety which marriage and family entails.

D. THE APOCRYPHAL ACTS OF PAUL AND THECLA

The Thecla story is part of an apocryphal book known as The Acts of Paul. Tertullian (198-200) rejected The Acts of Paul for its support of women in a teaching and baptizing role in the Church, although he did not denounce it as heretical. His contemporary, Hippolytus, used it without hesitation, and refers to it in his own writing (c.204). Origen knew and probably valued it. Eusebius grouped it with spurious writings which should not be used. Jerome, taking Tertullian one step further, rejected the Acts of Paul as heretical.[6] Thus, The Acts of Paul was never given canonical status, but, if it is not important as scripture, it is very important for those interested in early church history. Here it is important for a glimpse of the early communities' varied attitudes toward women, faith, and families.

The central figure in the Thecla story is the young woman, Thecla. Thecla is engaged to be married to a man named Thamyris, but one day she sits at a window where she can hear Paul teaching an assembly of Christians. Hearing his words on the virgin life "she did not turn away from the window, but pressed on in the faith rejoicing exceedingly."[7] Her mother and Thamyris are unable to turn her attention away from Paul's words, and the whole household falls into bitter

mourning. Thamyris weeps bitterly for the loss of a wife, Thecla's mother for the loss of her daughter, and her maids for the loss of their mistress.

In rage Thamyris goes to find who this Paul is so that he can take revenge. Two men respond to Thamyris saying, "Who this man is, we do not know. But he deprives young men of wives and maidens of husbands, saying: 'Otherwise there is no resurrection for you, except ye remain chaste and do not defile the flesh, but keep it pure.'"[8]

Thamyris, the city's rulers, and officers lead an angry crowd to arrest Paul. The crowd's complaint is that Paul by sorcery has corrupted their wives. Before the governor, Paul's testimony to Christ's holy works is given a sympathetic hearing, but Thecla is asked, "Why dost thou not marry Thamyris according to the law of the Iconians?" When she does not answer, her mother cries out, "Burn the lawless one! Burn her that is no bride in the midst of the theatre, that all the women who have been taught by this man may be afraid!"[9] Paul is scourged and driven out of the city; Thecla is condemned to be burned. However, she is saved from the burning by God's intervention and is reunited with Paul.

Thecla and Paul travel to Antioch where a Syrian named Alexander immediately falls in love with her and tries to purchase her from Paul, who denies ownership. Alexander seizes her by force, and in the struggle Thecla rips his cloak and knocks off his crown. Humiliated, he takes her before the governor, and once again she is sentenced to death--this time by wild animals in the arena. Again she is saved by miraculous means, and through her public salvation many of the city's

women come to believe. Once again reunited with Paul, he hears her story and then commissions her to teach the word of God.[10]

This vision of the role of women in the community has no place for Thecla's indenture to a husband and a household, certainly no place for romance. The objection to marriage is not whether the men who want to marry her are Christians or not; Thecla has been claimed by Christ and she is called to live the life of a virgin. For her calling she suffers public censure, humiliation, and nakedness, and is ready to face brutal death.

The Thecla story may have been a popular pre-Christian legend which was "Christianized" by adapting it and working it into the Acts of Paul. But whether or not it was a legend based upon the life of a Christian woman, it vividly conveys the widespread attitude of the church communities toward the value of the virgin life dedicated to Christ, at least two centuries before the establishment of monasteries and convents. It also witnesses to the importance the civilized world of that time placed upon women as wives and, hence, mothers, an orientation which many Christian communities did not accept.

E. SPIRITUAL MARRIAGE: AN EARLY EXPERIMENT

One of the earliest and most controversial forms of marriage practiced by Christians was the practice of <u>syneisaktism</u> (spiritual marriage). Derrick Sherwin Bailey defines it as "the cohabitation of the sexes under the condition of strict continence, a couple sharing the same house, often the same room, and sometimes the same bed, yet conducting themselves as brother and sister."[11] <u>Syneisaktism</u> was

celibate cohabitation. Denounced after heated debates by various church councils, it was never officially accepted as a legitimate lifestyle. We have no written documents from persons who practised spiritual marriage; we know it only from the view of its criics. Is origins are unknown. Paul may have been referring to it in I Corinthians 7:36-38.[12] By the second century there are numerous references to it. The practice seems to have been widespread, and difficult to eradicate.

How did such a practice emerge? One explanation is that before the establishment of monasteries and convents, to live the celibate life usually meant to live a totally solitary life. Men and women alike retreated to the wilderness where they lived extremely harsh lives, and often died within a few months. Syneisaktism opened a viable alternative, making possible celibacy and a modified asceticism. Women received the protection of marriage without its encumbrances. They were free to devote themselves to prayer and spiritual disciplines without the strict privations of the desert monks.

However, Elizabeth Clark offers another explanation for the phenomenon. She suggests that syneisaktism gave persons an opportunity for both spiritual and emotional intimacy with members of the opposite sex, an intimacy which was rare in late antiquity--even in marriage. Clark views the phenomenon not simply as a monastic experiment, but as an experiment in human relationships.[13] As such, it may represent the only example in antiquity in which the purpose of marriage was not to procreate!

Jerome attacked the practice vehemently, charging that the couples cheated on their celibacy vows. On the other hand, Chrysostom

assumed that the celibacy vows were being kept. And yet he, too, attacked the practice as a distortion of celibate life. Celibacy is not limited to a physical state, he reminds his readers, but is a spiritual orientation which requires the denial of all human love (philia as well as eros) which would easily engulf the celibate with worldly obligations.

Chrysostom, predating feminist objections by centuries, had problems with Timothy 2:14-15:

> and Adam was not deceived, but the woman was deceived and became a transgressor. Yet woman will be saved through bearing children (or, "by the birth of the child," i.e., Christ), if she continues in faith and love and holiness, with modesty.

The problem for Chrysostom was that he believed marriage's function was to tame sexual lust. He did not believe that children were the primary reason God insituted marriage. Instead, children were a solace, a compensation for humanity's loss of immortality in Adam and Eve's Fall. But Christians, with the hope of resurrection in Christ should not need such solace any longer. Chysostom believed that the bearing of children--like sexual relations--was a result of the Fall.[14] For the same reasons, Jerome severely criticized women who showed too much affection for their husbands or children, or childless women who yearned for offspring.[15]

The ideal of the Christian monastic life stressed the renouncement of family ties, social status, and sexual identity as well as sexual relations. The male or female celibate renounced all claims and calls to personal love and social (family) responsibility in order to answer what the Church and its culture believed was the ultimate

love. This resulted in a neutralization of marriage and family as the primary sources of an individual's identity. Jerome's and Chrysostom's thought, in spite of the negative attitudes toward women each ultimately helped to establish in western Christianity, was radically freeing in the sense that it relieved women of their identity roles as wives and mothers, and husbands as heads of households and fathers.[16]

F. CONCLUSION

Major underlying factors in an infertile couple's grief are the combined personal, social, and religious pressures for children. Marriage and children as the major identity-establishing factors in a man or woman's life remains an important faith issue. The intention here has not been to spiritualize childlessness, or to argue that it is a denial of faith to value children. However, some of the cultural-religious pressures in the church today to marry and have children may be relieved when these early traditions are reclaimed with new appreciation as a counter to the prevalent nuclear family bias of modern western culture and its churches.

Chapter IV

SOCIAL AND PHYSICAL ASPECTS OF INFERTILITY

A. INTRODUCTION

Infertility affects over five million couples in the English-speaking world. Three and a half million are in the United States and Canada. One out of ten wants a first child; three out of twenty want a second or third. There is no social profile for infertility; it affects the rich, the poor, the educated, the illiterate. It affects Third World families as well as those in the First World.[1] However, despite the range of this problem, it is obvious that most people never encounter infertility. Eighty to eighty-five percent of the human population have no difficulty conceiving. Their problem is finding effective and safe contraceptives.

Medically, infertility is the inability of a couple to conceive after a year of unprotected, random intercourse, or after six months of regular intercourse during the woman's fertile time. Infertility also involves the inability to carry a pregnancy to a viable birth, so habitual miscarriages are regarded as an infertility problem.

Procreation is the result of highly complex environmental, physical, and psychological interactions, many of which are not fully understood. This chapter discusses the most common social and physical influences which can prevent conception or a successful pregnancy.

B. CONTRIBUTING SOCIAL FACTORS

Whether the infertility rate is higher now than it was a century ago is debatable. With sexual behavior a more acceptable topic of conversation and new medical advances which open hope to many couples, some people risk admitting infertility who would not have a generation ago.

A variety of current social and environmental factors contributes to the infertility rate. Venereal diseases, abortion, birth control methods, certain types of pollutants, lifestyles which require continuous high stress levels, even drugs administered to women a generation ago--all take their toll. But of all these, perhaps the most significant factor currently contributing to infertility in the United States is the increasing practice of delaying parenthood.

This is a significant factor, because one in ten previously fertile women are infertile by age 35, one in three by age 40, and seven in eight by age 45.[2] Dr. Melvin Taymor of the Harvard Medical School insists that women over 35, because of the likelihood of rapidly decreasing fertility, should begin an infertility workup after only six months of trying to get pregnant.[3]

C. PHYSICAL CAUSES OF INFERTILITY

A small number of infertility problems are caused by congenital defects, such as the absence or malformation of the male or female genital system. Usually these are discovered in puberty, but sometimes they are not apparent until the infertility investigation. Very rarely there are chromosomal defects.

Occasionally the problem is intercourse itself. A couple might be having intercourse, but consistently at the wrong time. This can easily happen if the couple are trying to time intercourse and have misinformation as to when their fertile time is. For example, the couple may be watching the basal temperature chart, abstaining from sex until the temperature rise occurs, not realizing that that means that ovulation has already occurred, perhaps more than a day before. The problem of timing can also be difficult if the woman has a long menstrual period and then ovulates earlier than they normally resume sexual activity.

Severe emotional or physical stress, malnutrition, or poor health can also be contributors.

The rate of male and female infertility is approximately equal, but generally infertility is the result of multiple causes. In anywhere from 35%-80% of infertility cases, either one or both members of the couple will have several contributing problems.[4] Infertility represents an unusual medical condition because it is so often shared by two people.

Most physical causes of infertility fall into one of three categories: (1) faulty sperm or egg production; (2) barriers to the meeting and fertilization of the sperm and the egg; (3) faulty implantation of the fertilized egg which results in an early miscarriage, sometimes so early the woman is unaware that she was pregnant.

1. Causes of Male Infertility

A man is fertile if he is capable of impregnating a woman. In other words, he must be capable of producing a sufficient number of normal sperm and of depositing them in a woman's vagina. When the male partner contributes to a fertility problem, it is usually because of inadequate or abnormal sperm production or problems with depositing the sperm.

Faulty production can involve a host of problems. Quantity, quality, and motility (the ability of the sperm to move) are all essential aspects of an adequate sperm count. One man may have a high sperm count, but an unacceptable level of abnormal sperm which cannot fertilize an egg. Another man may have a low sperm count but sperm of good quality and motility. Few men produce no sperm at all; if sperm are present, there is always a chance of a pregnancy, although low quantity or poor quality lowers the chances proportionately.

The causes of faulty sperm production are varied. Malfunctions of the pituitary, thyroid or adrenal glands can affect sperm production. Sometimes the testicles did not descend into the scrotum, or they descended too late. Diseases like mumps orchitis in puberty or adulthood can destroy or severely damage a man's sperm-making capacity. Dilation of veins in the testicles, a condition called variocele, may also create problems. Injuries can cause temporary or permanent damage. Temporary environmental factors include poor nutrition, certain allergies and prescription drugs, and sometimes the use of alcohol, tobacco, or marijuana. Another common problem is heat, which kills sperm. Nature's system of storing sperm outside the body in the

testicles permits efficient cooling, but even minor interference--like wearing tight underwear, sitting for long periods of time (an occupational problem shared by truck drivers and white collar workers), taking hot baths or jaccuzis--can block the natural cooling process.

Problems which affect sperm's transport and deposit are fairly uncommon. Sometimes the sperm's path within the testicle can be blocked as a result of injury or disease. Impotence and ejaculatory impotence can be caused by injury, but they are often sexual disorders which require psychiatric therapy.

Because infertility has been seen first as a woman's problem--emotionally as well as physically--male infertility has not received the attention it deserves. Currently urologists treat men with infertility problems, but there are signs that a new medical specialty, andrology, is developing. Andrology studies the male reproductive system just as gynecology studies the female reproductive system. Male fertility is not simple; for years it has just been oversimplified.

2. Causes of Female Infertility

For a woman, fertility is the capacity to conceive and to carry a pregnancy. This requires the production of a healthy egg that successfully passes from an ovary into an open fallopian tube, an open pathway for the male's sperm to travel from the vagina through the cervix and uterus into the fallopian tubes, and a uterus prepared and capable of receiving the fertilized egg.

Of women who have an infertility problem, 20%-35% have difficulties involving the fallopian tubes, 10%-15% involving ovulation,

and 5%-20% involving the cervix.[5] Other problems include the malfunction of the thyroid or adrenal glands, chronic infection of the genital organs, or allergies to the husband's sperm. Vaginismus (severe constriction of the vagina) and frigidity can cause infertility only if they prevent intercourse. Vaginismus and extreme frigidity are rooted in psychological factors, and require professional therapy.

Fallopian tube problems are generally physical rather than chemical. The tubes may be partially or completely blocked, preventing the meeting of the sperm and the egg, or they may be held immobile so that they cannot pick up eggs from the ovaries. Blockages are caused by malformations or scarring due to injury or infection; immobility may be caused by adhesions--tough, threadike scar tissue which anchors the tubes in one position. Common causes of adhesions causing blockage or immobility are venereal disease, any pelvic infection, abortion damage, pelvic surgery (including appendectomies and Caesarean deliveries), and the use of the I.U.D. Tubal spasms can temporarily block tubes, and may indicate a bodily response to emotional or environmental stress.

Problems with ovulation may be caused if the pituitary does not stimulate the ovaries. The thyroid or adrenal glands can also interfere. Some physicians suspect that the effects of the Pill cause a woman to be anovulatory (no ovulation) for several months after she has stopped taking it.[6] Other experts suspect that the Pill merely masks an already existing ovulation problem. A woman should consult her doctor if she discovers, through keeping a basal temperature chart for three or four months, that she has not begun ovulating.

For the cervix, physical blockages such as growths or polyps, infections, production of mucus hostile to sperm, and physical weakness of the muscles can all cause infertility.

The failure of a fertilized egg to implant itself can be caused by an inadequate uterine lining due to a progesterone deficiency in the first three weeks of fertilization.[7]

D. SECONDARY INFERTILITY

Primary infertility refers to the condition of the childless infertile couple. Less well-known is the condition of secondary infertility. Also known as "single-child sterility," secondary infertility occurs when a couple who have conceived and birthed one or two children have difficulty conceiving another. Fifteen percent of couples who have one child are unable to conceive another, but the number could run higher since many of these couples fail to get medical help. Since they conceived once, it may never occur to them that they might have an infertility problem.

The fact of a first pregnancy usually rules out congenital and chromosomal abnormalities. But beyond that, the same factors which cause primary infertility can cause secondary infertility. It is possible that the couple had been on the borderline between fertility and infertility at the time of their first conception. Perhaps they were just lucky in conceiving their first child. Perhaps their fertility "rating" dropped just enough so that several years later they have difficulty conceiving. The woman may have developed endometriosis, polyps, or fibroid tumors. The man's sperm count may have dropped for

one of a variety of reasons. Injuries or diseases may have affected either the man or the woman--or both.

Ironically, pregnancy and birth can contribute to infertility. Postnatal infections and Caesarean scarring frequently cause problems later. The cervix can also be damaged by a baby's expulsion during birth.

E. MISCARRIAGE

Ten to twenty percent of all pregnancies end in unavoidable miscarriages (also known as "spontaneous abortions"), most within the first three months. The cause is usually a defective egg or sperm, but when two or three conceptions in a row end in miscarriages (termed "habitual miscarriage"), it is an infertility problem.

Some causes of miscarriage are very clearly understood, others are not so clear. There is debate over the interaction of miscarriage-producing factors. The endocrine system is implicated, but it is not clear whether those glands' misfunctions are a primary cause of a miscarriage, or a response to the already impending miscarriage. Miscarriages which occur within one to three weeks of fertilization can be caused by a progesterone deficiency, or sometimes by bacteria recently discovered called T-Mycoplasma which attack the fertilized egg. Hormonal imbalances may cause later miscarriages.

Physical defects of the uterus such as an abnormal shape, a weak cervix, or non-malignant growths which prevent implantation or cause uterine contractions sometimes lead to habitual miscarriage.

Less widely accepted as causes are immunologic reactions, physical activity, and emotional turmoil or trauma.

F. INFERTILITY TESTING AND TREATMENT

Couples often hesitate to see a doctor for infertility because they are afraid that they will have to undergo painful tests and surgery, and that the procedure will be a very expensive process. This need not be the case. A few tests cause discomfort, but not enough to prevent a couple from starting them. Many conditions are not surgically treated, and surgery is normally reserved until all other possible causes are ruled out. The couple should feel that they are in control of the infertility workup and should feel free to stop at any point for re-evaluation of the personal priorities before continuing. Infertility testing can be emotionally exhausting, and many couples are relieved when it is over. If testing or treatment extends beyond five or six months, a "breather" may be helpful.

A basic workup should be able to be completed within four to six months. Cost depends upon the doctor and the laboratory that processes some of the tests. Specialists charge more but are likely to be more effective if they have more specialized training and experience. In the long-run, it may cost less to start with a specialist and thus avoid having to redo tests--or surgery--done earlier by a non-specializing gynecologist. Some large health programs have infertility clinics, as do most teaching hospitals associated with medical schools. Teaching-hospital infertility clinics often charge their patients on a sliding scale according to income. Insurance companies may or may not

cover infertility testing and treatment.

1. The Sperm Test

In the initial male test, the man simply provides a sample of semen in a clean dry jar. The specimen is examined under a microscope and analyzed for the number of sperm of normal size, shape, and motility. Sperm counts may vary from day to day, so one or even more low counts are not always a sure sign that too few sperm are the problem.

When the sperm count is moderately low, general health is built up. Intercourse may need to be carefully scheduled to increase the chance of fertilization. Sometimes a thyroid deficiency is noted. If sperm are weak, many couples choose artificial insemination with the husband as donor. The strongest portion of the ejaculate is placed either at the opening of the uterus or further into the uterine cavity during the woman's fertile time.

Lack of sperm may indicate either no sperm production, or blockage. Relief of blockage can sometimes be achieved surgically, but there is no cure for lack of production. Artificial insemination by a donor is the choice of some couples faced with this problem.

When a man refuses to have the sperm test done, some doctors continue to work with the wife in case the infertility is her problem. However, the refusal to participate may indicate a serious lack of commitment on the husband's part and should be suspected as a symptom of a breakdown in the marriage relationship which may or may not be related to the infertility problem. Sensitive counseling intervention is

required at this point. Continued testing for the wife is expensive and can involve physical risk. It is not advised until the sperm test is done.

2. The Post-Coital Test

Normally the vagina is hostile territory for the sperm. The sperm must escape it by moving through the cervix into the uterus, or womb. The post-coital test tells how the sperm behave in the woman's body. Also called the Sims-Huhner test, the post-coital test gives evidence as to whether sperm have been able to migrate into the uterine cavity.

The test is performed several hours after intercourse by taking secretions from various levels of the cervical canal and the uterus for microscopic examination. There is little or no discomfort.

A post-coital test which finds few or inactive sperm from a man with a normal sperm count may indicate an inflammation or infection of the cervix which is killing the sperm. The condition is treated by cauterization of the cervix, or small doses of estrogen if a hormonal imalance is creating a secretion hostile to sperm. Artificial insemination may be used to place the husband's sperm safely beyond the cervix.

3. The Basal Temperature Graph

This ovulation test is done by the woman in her own home and can be begun while the couple are waiting for the first doctor's appointment. It is inexpensive and simple to do but requires patience

and consistency. Many find it a frustrating discipline.

A basal temperature thermometer is purchased over-the-counter at a pharmacy. Every morning immediately upon awakening (preferably at the same time each day) and before any activity, the woman takes her temperature and charts it on a graph. A normal chart for a month during which ovulation took place is characterized by a "biphasic" or "two-phase" graph. That is, the graph shifts from a low point to a higher plane indicating that ovulation took place. If there is no distinct difference between the first half of the month and the second half, the chart is "monophasic," indicating that ovulation probably did not occur.

Three or four months of charts are necessary to show the individual pattern. Some couples find the anxiety aroused by watching the chart more than they are willing to cope with. It can also cause trouble when one or both are interested in some spontaneous morning love-making, and spontaneity has to be put "on hold" while the woman takes her temperature. Other couples enjoy following the woman's body rhythm and feel satisfied to be doing something which gives them a feeling of control.

The charts are not able to pinpoint the exact time of ovulation, so they can not be used to time intercourse. They simply show if ovulation occurred and approximately when. There is usually a definite and sharp rise in temperature, but this does not always come at ovulation time; a "lag time" in hormonal response can delay the temperature rise. Generally a physician needs to interpret the charts to distinguish individual variation from diagnostically significant

data.

Some women need an endometrial biopsy to confirm ovulation. This is done in a doctor's office, but it is a painful test. A local anesthetic can be given.

If ovulation is irregular, it can be regulated with a drug like Clomid. If signs are that ovulation is not taking place, further tests may show the reason. A thyroid deficiency is easily corrected. If the ovaries are not producing eggs, a "fertility drug" may be used. Complete ovarian failure (premature menopause) cannot be remedied. In a few years, egg or ovary transplants may be an answer for this condition.

4. Fallopian Tube Tests

Fertilization takes place in the fallopian tubes, with sperm swimming upstream and the egg moving down toward the uterus. The channel is no larger than a straw, and anything which narrows it can prevent passage of the egg or sperm--or both--and thus interfere with conception.

Generally, three overlapping but separate tests are required to determine if the tubes are in good condition.

The Rubin Test. This widely used test consists of passing carbon dioxide gas under measured pressure through the tubes. When the woman sits up, she will feel pain in one or both of her shoulders, caused by the carbon dioxide bubble rising and pushing against her diaphragm. Shoulder pain is a good sign because it means the tubes are

open. If there is no shoulder pain, or if it occurs after some delay, it probably indicates blockage. Sometimes the tubes are only temporarily closed by a spasm and will open with a relaxant or anesthetic.

Hysterosalpingogram. The second tubal test involves taking pictures of the inside of the uterus and tubes. Special dye is injected into the uterus and tubes. The resulting pictures reveal any abnormality in the shape of the uterus as well as marking areas of partial or total tubal blockage. If the tubes are open, the dye spills out into the abdominal cavity and is absorbed.

Both the gas for the Rubin test and the dye injected for the hysterosalpingogram can be sufficient to break through a minor blockage, and many women conceive within a month or two. Some physicians have replaced the Rubin test with the hysterosalpingogram.

Endoscopy. Both the Rubin and the hysterosalpingogram can give "normal" results when the tubes are not normal. For example, the tubes may be corkscrew-shaped or tapered rather than funnel-shaped at the end. Either condition would prevent the passage of the egg. Endoscopy is a method which enables the physician to see the uterus, ovaries and tubes. A periscope-like instrument with a tiny lighted bult on the end is inserted into the abdominal area.

Culdoscopy involves vaginal entrance; laparascopy requires "band-aid surgery," with entry through the abdomen. Both are hospital procedures, but they can generally be done on an out-patient basis without difficulty. Which is done depends on the physician's

preference.

Treatment of tubal closure may require doses of antibiotic and cortisone injected into the tubes, or surgical reconstruction. The latter has a less than 50% estimated success rate.

G. CONCLUSION

Although the woman is usually the first to seek help, the man is the primary contributor to an infertility problem as frequently as she is. More importantly, 35%-80% of infertile couples share the infertility, with each contributing one or more physical factors. Infertility is not a woman's problem, and it is not uncommon.

Infertility can be reversed. As many as 80%-90% of the couples who complete a thorough investigation will find a reason for their infertility. Of these, approximately 50% can be helped to conceive and carry a pregnancy, a rate impressive when contrasted with the 5% spontaneous recovery rate.

Infertility specialists hope a major breakthrough in treatment will come as more is learned about what causes the fallopian tubes to move to the ovaries to pick up the egg (ovulation does not guarantee that the egg ever arrives at the tube), how conditions in the tube help or hinder the meeting of sperm and egg, the effect of seminal fluid on its sperm's lifespan and motility, and male and female immunologic reactions which may destroy sperm or the fertilized egg.

The fact that a couple have no diagnosis may indicate the limitations of medical knowledge or the quality of medical resources the couple has had available to them. The lack of a clear diagnosis is not

conclusive that there is no physical problem.

Chapter V

THE INFLUENCE OF PSYCHOLOGICAL FACTORS

A. INTRODUCTION

The psychological factors which contribute to infertility are not well understood at this time and are sharply disputed among medical and psychological experts in the field. Specialists in the psychological aspects of infertility and specialists in the physiological aspects do not often overlap in their treatment of infertile couples. However, the growing respect for the intricacies of the mind-body interaction is of great importance for the kind of treatment and support given the infertile person or couple.

B. PSYCHOGENIC INFERTILITY

Several terms are used for physical conditions influenced or caused by the emotions or the personality at the subconscious level. Psychosomatic is the most familiar lay term. Psyche refers to the mind; soma to the body, thus psychosomatic. Unfortunately, calling a disease or disorder psychosomatic implies for most people that it is an imaginary disease. Psychogenic is a less emotionally "loaded" term. It refers to the mind as the generating location of the disease. Functional is used interchangeably with psychogenic. To say that a woman or a couple is functionally infertile means that no organic cause has been diagnosed, but no pregnancy has ensued. It may also mean that although an organic cause has been identified, it is probably directly

influenced by psychological or emotional factors.

Since at least the time of Freud, infertile women have been suspected of mental disorders ranging from the minor to the most serious psychological and emotional disorders. The implication that the infertile woman is infertile by choice adds insult to injury to the woman who is desperate to achieve a pregnancy for herself and for her husband. Current popular books dealing with infertility mention psychological factors only in passing, if at all. Many physicians discount theories propounding emotional roots for infertility, and the apparent suggestion of mental illness is intolerable for most infertile couples.

To say that an infertility problem may be psychogenic unfortunately implies that the woman is wilfully refusing to have a child, either through conscious deception, unconscious hostility, or emotional instability. Most couples would be very threatened if either one of them was told that his or her problem was "psychosomatic," or "all in your head." A common anxiety shared by many persons before consulting a physician is that they will not be taken seriously, and that they will be told their infertility is "from the neck up." Yet no such value judgement is involved in other psychosomatic (mind-body) responses such as ulcers or high blood pressure. The mind (psyche) and the body (soma) are not separate in fact, and cannot be separated even in theory. The distinction between diseases with organic causes and those which are psychogenic in nature is often vague. Diseases which have identifiable organic causes implicate the mind in terms of the body's susceptibility to illness and its powers of regeneration.

Infertility obviously affects the emotional state of the infertile person or couple, but it is also affected by one's personality and adaptive responses to the physical and social environment.

C. PSYCHOLOGICAL RESEARCH

In 1956 researchers Stone and Ward analyzed 500 infertility cases successfully treated at the Margaret Sanger Research Bureau. Seventy percent of the cases had involved primary infertility, and 30% secondary infertility (one or more previous births). They concluded that nearly 25% of the subsequent pregnancies were achieved after an improvement in emotional or psychological factors. Ward later extended the study to 1000 pregnancies of infertility cases. He went so far as to attribute pregnancy to the improvement of psychological factors alone. Improvement was seen to be related to acceptance of the situation by the couple, and relaxation through the transfer of the burden to the physician.[1]

In another study, 1437 infertile couples were followed. Thirty-nine percent of these couples eventually became pregnant, but a whopping 24% became pregnant within the first two months of the initial infertility interview, regardless of the treatment; this fact supports Ward's theory that transferring the emotional burden to the physician was a major part of the therapy.[2]

Psychological factors enter the picture in a variety of forms. Common problems which may be partially or wholly related to psychological factors in the female are menstrual disturbances, tubal spasms, and a disrupted pituitary-ovary-endometrius interaction. Overt

responses to subconscious resistance by either the male or female may include breaking the basal temperature thermometer or forgetting to use it at crucial times, avoiding sex during the fertile period, or forgetting scheduled clinic appointments. Men may experience periodic impotence.

Cheema observes that attitudes and anxiety are interpersonal in nature. The human individual is not a closed, self-contained system, but an open system which is constantly in interaction with other persons and with the enviromment. Her research centered on the husband-wife interaction in cases diagnosed as functional, or psychogenic, infertility. However, it is possible to extend her field of interaction: the couple, and not simply the individual, is an open system interacting with its environment. If infertility is affected by psychological factors, then improvements in the larger family and social systems will have beneficial emotional and physical effects.

Ivanna Richardson sought to determine if infertile women could be identified through personality testing. Are there traits which functionally infertile women have in common? If so, then psychological evaluation and treatment should be included as part of the normal infertility workup and, if psychological factors are implicated as primary or contributing causes, a psychologist, psychiatrist, or trained counsellor should work with the infertility specialist in making decisions regarding treatment. (Therapy may be in order if, for example, a woman is unconsciously resisting pregnancy while consciously working for it.[3] Intervention may also be needed if one spouse is actively working for a pregnancy while the other is either consciously

or subconsciously sabotaging those efforts.

Kroger, one of the major figures in the psychological study of infertility, wrote that he was surprised at how frequently personality problems are ignored as causative variables. He was concerned that the physician could be opening a hornets' nest by enabling a pregnancy. Mandy et al. noted that doctors treating infertility heed the infertile woman's desire for a child as a command and very rarely question her and her husband's right to have a child. Physicians require adoptive parents to be emotionally stable, but no such demand is placed upon infertile couples.[4]

Kroger estimated that a major portion of infertility is due to psychogenic causes. He held that infertility was often caused by the interaction and interdependence of emotions and bodily functions. The husband-wife interaction was seen to have great significance. Kroger was concerned that if a woman subconsciously had rejected pregnancy but through therapy became pregnant, she might act spitefully toward the child.[5]

Adoption workers want to be reasonably sure that a couple has worked through their feelings toward infertility before a child is placed, since sometimes the adopted child evokes parental resentment by serving as a reminder of their "failure" to have a child of their own. However, if Kroger is right, the same thing could happen with a biological child born as a result of infertility treatments. Kroger would suspect that the resentment was not due to whether the child was biologically the couple's or whether it was adopted, but to whether the individual or the couple had accepted the parenting role. Following

Kroger's opinion, researchers Mandy and Mandy questioned whether doctors are justified in forcing functionally infertile patients by "potent therapeutic measures" into a role for which they may be emotionally unprepared.[6]

Richardson identifies six recurring themes in the literature dealing with functional infertility. Classically, infertility has been seen by psychological researchers as the consequence of one or more of the following: (1) a serious inner conflict; (2) the fear of pregnancy, and all that a pregnancy entails; (3) a deep-seated mother hostility which causes a woman to reject the mother role for herself; (4) anxiety and tension arising from a psychologically stressful situation; (5) an inability to resolve dependency needs in order to accept a child's dependency; (6) deep dissatisfaction with the marriage partner. The latter may be one contributing factor in the cases in which a couple is infertile, but in second marriages each spouse produces children.[7] Various researchers and writers place emphasis upon different areas, but by and large they agree that functional infertility is the result of one or more of these factors.[8]

Kroger believes that any strong conflict over the ability to fill a maternal role can affect ovulation or implantation.[9] Pohlman holds that conscious desires to have, or to avoid having, children may not be as important as the total personality pattern. Farrer-Mescan sees the marriage to be central in any infertility investigation. In addition, he believes that any marriage facing infertility needs to have an assessment of its strengths and weaknesses in order to enhance the relationship regardless of the infertility investigation.[10]

Eisner's research concluded that infertility is emotionally disturbing, but that the amount of the disturbance depends upon the personality, length of infertility, the period of unsuccessful treatment, and the amount of pressure on the individual to bear a child. However, she found a disproportionate number of functionally infertile women with serious schizophrenic disturbances which she felt could not have been caused by the infertility. She argued that serious emotional disturbances play a role in functional infertility.[11]

These researchers have in common the perception of infertility as a psychological defense mechanism, a symptom which functions to safeguard organic-psychic equilibrium and to alleviate internal stress. In common with medical researchers, the psychologically-oriented researchers agree that fertility is a fluid, elusive quality which comes and goes, differing from one person to the next, and changing with the individual's emotional and physical maturation pattern. Conditions which result in the temporary or permanent infertility of one couple may not affect the fertility of another.

D. EFFECTS IN MEN

Researchers interested in the psychogenic aspects of infertility have focused almost exclusively upon the role of the woman in psychogenic infertility. The overwhelming assumption has been that if the couple does not get pregnant, and there are no identifiable organic causes, the woman is probably subconsciously refusing a pregnancy. Few studies have been done on the psychological dynamics in men which could affect their own or their wife's fertility.

One of the first to note the male's role in psychogenic infertility, in 1955 researcher Fischer wrote:

> I believe that the male plays almost as important a role, although he has been sadly neglected by those interested in this approach to the subject. The efficiency of emission reflex is therefore an important factor in the estimation of male infertility. From my own observations on many patients, there seems to be no doubt that the quality and quantity of the spermatazoa is influenced by emotional factors.[12]

In Germany, H. Steve studied men waiting verdicts in rape trials and discovered that their production of spermatazoa was in complete arrest.[13] Palti also studied the psychological factors in male infertility. He concurred with Fischer in 1969 that "there is little doubt that sterility in the male due to disturbed spermatogenesis may result from emotional stress."[14] Thus, stress has been shown to be related to infertility in men, but relatively few other infertility studies centering on men have been done; the bulk of the research is still concerned exclusively with women.

E. PSYCHOLOGICAL PROFILES OF FUNCTIONALLY INFERTILE WOMEN

Classically, two types of women have been identified as having a high incidence of psychogenic infertility. The first is the emotionally weak, immature, dependent, and overprotected woman.[15] She often has a parent-child relationship with her husband which she does not wish to lose, and she unconsciously resists moving into the role of the emotional nurturer. She might express her desire <u>exclusively</u> in terms such as, "I want to be pregnant because a woman gets special treatment when she's pregnant." As a mother, this personality type is usually seen by outsiders as a gentle nurturer, a good mother. Her dependency

needs may cause problems for family relationships, however. She is a woman who internalizes personal and interpersonal conflict and frequently complains of being tired or depressed. Fischer subdivided this group into two groups: (1) women who are afraid of motherhood, and who feel their own upbringing was inadequate; and (2) women who are afraid of pregnancy, death, and loss of figure or husband.[16]

A second classical type represented in the psychogenic infertility group is the aggressive and masculinely competitive woman. Fischer identified these women as those who were mothers to weak husbands, career women who unconsciously reject the mother role, and masculine aggressive women who refuse to accept femininity.[17]

Ivanna Richardson sought to discover whether these two types of women were accurate representations. Would objective personality tests reveal these personality types in women who had been treated for infertility? She studied 91 women, ages 19-34, 44 of whom were fertile with no history of difficulty in conceiving or carrying, and 47 of whom were classed as infertile.

The infertile group had problems with lack of ovulation (anovulation), absence of periods (amenorrhea), tubal spasms, hostile cervix mucus, polycystic or sclerocystic ovaries, endometriosis, and related conditions. Each of these conditions hinders, but does not necessarily rule out pregnancy. Each condition is believed to be emotionally induced and regulated. There is strong evidence that they are related to psychological difficulties.[18] Medications that induce ovulation, argues Richardson, may not prove that the problem was exclusively organic in origin, but instead may override and bypass

psychological factors which might be of real consequence in the woman's infertile status.

Richardson concluded on the basis of her research that accurate classification of women into functionally infertile or fertile groupings can be made. The nature of the differences she found in her limited group tended to describe the aggressive and masculinely competitive woman; no basis was found for the emotionally and physically immature personality. This was probably due to the self-selection process--the infertile women who responded would tend to be more outgoing and aggressive women. All the participants considered themselves to be healthy; infertility was not felt to be a sign of illness.

Richardson argued on the basis of her testing that personality does play a role in functional infertility, and that high-risk functionally infertile women can be identified through personality tests.[19] For the most part, the differences between the infertile and the fertile groups were negligible, but two areas had distinct differences. The infertile women as a group scored very high on the need for achievement. Richardson suggests that the emotional need for personal and professional/social achievement which can block pregnancy may also make the woman intolerant of her failure to become pregnant, so she seeks medical help. But the infertile women also scored high in "endurance." Richardson writes,

> Endurance is directly related to a capacity to withstand stress and to maintain one's defenses of an active rather than passive nature. It also tends to strengthen other personality characteristics possessed by an infertile female. Thus, endurance may be a direct contributor to the maintenance of one's defenses, which . . . result in infertility.[20]

The profile description of the functionally infertile woman Richardson studied shows a woman who is a striver. She values self-improvement, aspires to high goals, holds high standards for herself and for others, and takes on difficult tasks. She responds positively to competition. She is patient, persevering, and unrelenting. She needs to be at the center of attention, and may be entertaining or showy. She needs to control her environment and the people about her. She expresses her opinions forcefully. Governing, controlling, commanding, assertive, she is independent and less likely than most of her sisters to seek the sympathy, advice, or protection of others. This closely corresponds to the masculine aggressive competitive type earlier researchers described. However, one must be clear, first, that this is a profile of a group, not of an individual; second, that the group profile emerged out of a very small sample; and third, that the Personality Research Form may have the same weakness in terms of sexual bias in terms of defining "feminine" and "masculine" traits for which many of the current personality tests have come under attack.

F. INFERTILE COUPLES

In 1973, researchers Platt, Fischer, and Silver compared personality traits and self-concepts of infertile couples. Their study showed that infertile women showed more emotional disturbance than fertile women, consistent with earlier researchers.[21] More importantly, they found that infertile men and women view themselves as being externally controlled, and show a wide discrepancy between their present

selves and their ideal selves, as well as their conceptions of the ideal mother or father.[22] The perception of being externally controlled may not be a causative factor in infertility, however; it may be an indication of the emotional response precipitated by infertility.

Physicians are not oriented toward expecting or looking for possible psychological factors which may be contributing to, or causing infertility. Walker maintains that the literature on sexuality, urology, andrology, endocrinology, and gynecology seriously underplays the role of depression in infertility. He feels that the diagnosis and treatment of depression should interrupt the infertility workup.[23]

Kroger questions whether infertile couples should receive medical treatment without also having screening and/or psychological testing and counseling which might reveal sound reasons for a particular couple not being parents. Perhaps a less threatening and more growth-enabling approach would be to make professional counseling available as a normal--and expected--part of treatment so that goals for childbearing could be examined and re-evaluated, and the marriage relationship could be deepened and enriched. For some couples, the counseling relationship could make the trying time of infertility investigation easier. Others might discover that their commitment to children was not as important as they had thought and voluntarily choose a childfree life. For still others, underlying anxieties concerning pregnancy and parenting might be recognized and, through recognition, lessened. In a few cases, infertility will be only one of several serious marital problems involving alcohol, drug abuse or dependency, a history of family violence in one or both of the partners' backgrounds,

or a serious inability to communicate and to satisfy mutual emotional needs. These non-fertility issues are not unrelated to the medical investigation; as psychological factors are inproved, the physical condition may also improve and treatment be more effective. Counseling and care should be seen as essential therapy.

G. COUNSELING RESOURCES

The counseling scene for infertility at the present time is not encouraging, although because of increased popular interest it may begin to improve. Persons who have specialized or taken special interest in counseling infertile persons and couples to a large extent have been pioneers charting their own courses. There is no professional standard for infertility counselors. Most infertility counselors are social workers who have picked up their infertility expertise through personal and/or professional experience. They may or may not be qualified to identify and deal with the emotional issues involved for a particular couple. Certified marriage and family counselors probably have the best background for understanding the systemic dynamics of a couple in crisis or under stress. Few ministers, who in many communities are the main source of counseling services, have any introduction to the physical or emotional dynamics of infertility, but with this background they are probably the most effective source of support and counseling in a community because of their accessibility and their expertise and experience dealing with persons in crisis and grief. Infertility is the result of a complex web of medical, emotional, and psychological disruptions, and needs to be treated from all angles with extreme

sensitivity, good humor, and educated realism.

H. CONCLUSION

It needs to be stressed that infertility is not necessarily a sign of emotional difficulties. Scarring, flattened tubes, blockages, and other damage resulting from injuries or illnesses are not psychogenic in nature. However, the person who undertakes to counsel or otherwise support the infertile couple should not be concerned with whether the infertility is "valid" (i.e., purely organic) or whether it is psychogenic. If the couple is not able to conceive or to complete a pregnancy, they are infertile, whether the problem is psychogenic, purely organic, or, more likely, a result of the interaction of psychological and physical factors. Informal or formal counseling should focus upon the alleviation of emotional stress and anxiety by helping to enable nurturing family relationships and a higher level of self-esteem through decision-making behavior which returns a feeling of internality to the person.

Chapter VI

THE ETHICAL ARGUMENTS: RAMSEY AND FLETCHER

A. INTRODUCTION

This chapter discusses the ethical issues and arguments involved in contemporary responses to infertility. Couples who consider medical treatment, adoption, or other alternatives are confronted with a variety of difficult ethical issues and decisions but few tools for dealing with them. Instead, they are left trusting their physician and their own "gut feelings." It is imperative for any person who works with infertility as a representative of the Christian community to be acquainted with the main lines of thought in contemporary ethics and their sources in Christian history. This chapter focuses upon the works of two well-known ethicists: Paul Ramsey's Fabricated Man, and Joseph Fletcher's The Ethics of Genetic Control: Ending Reproductive Roulette. Paul Ramsey argues cogently and forcefully from a traditional standpoint, emphasizing an ethics focused on whether or not the means are justifiable in light of Christian tradition and theology. Joseph Fletcher also works from a dominantly Christian tradition of ethics, but as the originator and advocate of "situation ethics", he is more concerned with the motives and the result of an action. Neither ethicist deals extensively with infertility, but their work on the ethics of genetic control and research has much which directly applies to issues of infertility.

B. THE RIGHT TO PARENT

The brochure advertizing an infertility support group states, "A desire to parent is a basic human right." Ignoring the grammar, this is appealing rhetoric for any infertile person who wants a child. But is there a "right" to parent? Both Fletcher and Ramsey deny there is such a right. Paul Ramsey points out that traditional Judeo-Christian teaching holds that a couple perform their duty to the future generations of humanity through the procreation and education of children, but procreation has never been held to be primarily a matter of personal or parental gratification. Indeed, in some circumstances the obligation might be not to have children. Joseph Fletcher concurs and argues that biological parenthood is not necessarily the best thing for every person. Some place it as their greatest priority; for others it has no place. But for still others it undesirable even if they want it, for example, in cases where genetic disease, neglect and child abuse, or parental inadequacy in spite of all good intentions are involved.[1] Any uncritical claim to the "right" to reproduce must be opposed. There is no right to have children for the sake of the man or the woman.

C. SEX AND PROCREATION

The assumption that men's and women's basic function is to make babies is very strong in our culture and directly contributes to the anxiety of those who are involuntarily infertile. The belief, says Fletcher, comes indirectly from influences like the great fourth-century

theologian, St. Augustine, who insisted that sex is only permissible if it aims at or is open to conception.[2] Nature's intended end of intercourse is procreation, therefore anything which interferes with conception is sinful. Love-making on its own merits Augustine held to be sinful and selfish.[3] Of course, love-making did not have to produce babies, but intercourse could not be willfully separated from its intended aim--procreation.

Fletcher remarks that this attitude is still "quite common among doctors of medicine as well as doctors of divinity."[4] The twelfth edition of the classic medical textbook, Williams' Obstetrics (1961), declares that pregnancy is "the highest function of the female reproductive system."[5] This widespread and pervasive concept cultivates the attitude that extended non-pregnancy is immoral, if not pathological.

D. RAMSEY: FABRICATED MAN

Paul Ramsey's central argument in Fabricated Man follows Augustine's reasoning: human sexual intercourse has both a unitive purpose and a procreative purpose.[6] Humans are both body and soul, and this body-soul unity prohibits the possibility of locating the humanum of a person in thought or freedom alone. Human will is not free to exercise dominion over the human body. Ramsey flatly denies the position which holds that anything that can be done technically to control procreation may be done if it is voluntary and desirable.

He avoids the position of arguing against birth control, however, because it may be the most responsible act to take if

overpopulation, poverty, health, or genetic problems are involved. Birth control affirms the unity of the sexual act as both unitive and procreative by its assumption that if children are born to the pair, they will be born out of the sexual relationship!

The Christian understanding of the oneness of the "personally unitive purpose and the procreative purpose of human sexual relations"[7] has direct bearing upon the question of what means are legitimate to use in the treatment of infertility. Ramsey is concerned with the legitimacy of the means as well as the desired end. He challenges the use of artificial insemination by donor, artificial inovulation or egg transfer (involving implanting a donor egg into the infertile woman's uterus), as well as other experimental methods. A Christian, he argues, must evaluate the means to be used as well as the goals. A particular treatment might succeed but still be intrinsically wrong to use. An ethics of means can not be derived from, or dependent upon, the objectives of the action.

The essential problem defined by Ramsey is this: should sexual intercourse as an act of love ever be separated from sexual intercourse as a procreative act? Ramsey says not. Sex is an act of love and a procreative act at the same time. It is certainly not always procreative, and not always even loving, but its nature is dual, even if an obstruction (an uncaring or angry person, infertility, or birth control) prevents the realization of one of its ends. Ramsey believes that any ethics which separates these two ends, by arguing that sex is human and free while procreation is a technical, controllable issue, pays serious disrespect to the nature of human parenthood.[8]

Ramsey passionately argues that "to put radically asunder what God joined together in parenthood when he made love procreative, to procreate from beyond the sphere of love (artificial insemination by donor, for example, or making human life in a test-tube), or to posit acts of sexual love beyond the sphere of responsible procreation (by definition, marriage), means a refusal of the image of God's creation in our own."[9] What is at stake is not the right of a man and woman to pass on their genetic traits, for there is no such right; rather, what is at stake is the basic human bond between personal love and procreation.

Science and technology have aided the acceptance of a view of persons in which the biological dimension is an object submissible to human dominion. But human parenthood is a basic form of humanity, and any violation of the nature of human parenthood is dehumanizing. Ramsey criticizes even the use of the term "reproduction" because it is a manufacturing term. He prefers the term "procreation." To systematically de-biologize humans, he says, is to destroy humanity:

> When the transmission of life has been debiologized, human parenthood as a created covenant of life is placed under massive assault and men and women will no longer be who they are. Mankind will no longer be, for man is no more nor less than sarx (flesh) plus the Spirit of God brooding over the waters.[10]

Paul Ramsey was not writing specifically on the issues of infertility, but on genetic control. However, one can fairly safely infer from his work that his objection to infertility work would not be to medical treatments designed to remove obstructions to pregnancy (such as low sperm count, blocked tubes, hormonal insufficiency), or to treatments to preserve the health and safety of a conceptus or fetus in utero; his objection would be to any act which separates marital

intercourse from conception. According to Ramsey, artificial insemination, egg transfer, surrogate mothers (hostess gestation) and *in vitro* fertilization are unacceptable regardless of the pregnancy which might result. One might wonder whether the bane of infertile couples--scheduled intercourse--would also be de-humanizing in Ramsey's view, but since the *tendency* of the sexual act toward intimacy is not blocked, the sexual act retains its dual purpose of both intimacy and procreation.

Ramsey's position appears harsh and unacceptably tradition-bound to many, but he speaks from a position held on an emotional level by the majority of the population today both in and outside the churches, and thus his arguments need to be recognized and understood. For example, a couple may balk at artificial insemination for two reasons. One may be the desire that their child be born out of the intimacy of their intercourse. Artificial insemination violently intrudes into this intimacy. "Having a baby should be a natural, intimate affair, an expression of our love and life together!" the couple cries. When parenthood cannot come about naturally and spontaneously, the couple may feel very torn. Their desire was not simply for a child, but for a child born out of their sexual union. This desire, according to Ramsey, is in accord with the ethical imperative of the marriage covenant.

A second may be the couple's intense desire that a child carry their genetic traits. Ramsey, of course, points out that reluctance or refusal to accept treatment which involves the egg or sperm of a third party cannot be based upon the couple's feelings of genetic proprietorship because the couple has neither an inherent right nor a

duty to pass on their genes.

E. FLETCHER: THE ETHICS OF GENETIC CONTROL

Joseph Fletcher's The Ethics of Genetic Control is precisely opposed to Paul Ramsey on nearly every point. First, he attacks the assumption that scientific mastery drives out religious mystery. He objects to the attempt to preserve the mystery of baby-making and birth by a hands-off attitude. This attempt, Fletcher contends, is often indicative of a passive-dependent piety, a yearning for the blissful ignorance of the Garden of Eden.[11]

Uneasiness behind the opposition to reproductive research lies in the belief that the natural is better than the artificial, and medicine interferes with many of the natural processes. The opposition (Paul Ramsey chief among them) complains that egg transfers and transplants, and artificial insemination are "an assault on marriage and the human family," and that such depersonalizing and dehumanizing techniques will destroy the family institution.[12]

There is strong sentiment that going outside of the normal mode--coitus--is both unnatural and immoral. This sentiment arises out of a strong sense of human romance, a respect for the force of interpersonal relations, and the deep mutual commitment of the husband and wife in their love-making and their baby-making. The phrase "in a family way" indeed means more than simply being pregnant; it also refers to an intricate stucture of human ties, and a process of creative satisfactions.[13] Pregnancy plays an important role in preparing both the man and the woman for the demands and the joys of parenthood.

Fletcher willingly accepts the power and relevance of these arguments but counters that insemination or enovulation from a third party donor is not an invasion of monogomous marriage rights if the couple agree between them to choose it. Fletcher's emphasis is always upon the moral nature of human and moral relationships, over the physical, and if a relationship is moral and personal rather than physical and sexual, there can be no physical threat to the marital bond. If fidelity and integrity are based on a personal relationship, then an adopted child, a child born by a surrogate mother, or a child born through the methods of artificial insemination or egg transfer would be fully and truly one's own, whereas a battered or neglected child would not be the child of its genetic and biological parents.[14]

Catholic theology--representative of much Protestant and Jewish theology in this area--contends that the use of donor seed or egg is an intrusion into the monopoly of monogamy. Artificial insemination or egg transfer is immoral no matter how generous or humane the motive, no matter how impersonal or nongenital the means, no matter how much in agreement the couple is. The sperm and ova are as much a part of the person's sex as the genitalia. Marriage is a morally exclusive sexual relationship. Thus the child conceived from donor insemination or an egg transfer is regarded as illegitimate. This theological decision allows insemination which uses the husband's sperm, provided that it uses only the male fluid ejaculated during intercourse. Total AI--whether by husband or by donor sperm--is prohibited. For Catholics, Orthodox Jews and many Protestants, sexual intercourse within a marriage is essential for legitimate procreation.[15]

Fletcher argues that this raises questions about the nature of human relationships, marital fidelity, neighbor love, and human helpfulness.[16] Just as in pre-formula days it was expected that a nursing mother would nurse an infant born to a woman who could not provide milk, we may soon see the day when we expect fertility to be similarly shared. He gives the example of a charitable order of nuns in Rome who contribute their post-menopausal urine for FSH research. The urine is used to make the drug Pergonal to treat ovaries which do not release eggs.[17] Artificial insemination, hostess gestation, gonad transplants, and egg transfers all make possible a concept of shared fertility undreamed of in earlier generations.

Opponents of fertility and genetic research charge that any action which separates biological reproduction from sex is an attack upon the insitution of the family. In a sense that is true. Insofar as family relationships are perceived as primarily biological, the traditional concept of family is deservedly challenged. But current infertility methods also deepen the perception of the family. What do we think it means to belong to a family? What constitutes authentic relationships? Is "family" primarily a biological relationship--or is "family" forged in moral, mental, and emotional relationships?

F. CONCLUSION

This chapter has surveyed two works by Paul Ramsey and Joseph Fletcher as they shed light upon issues raised by infertility experimentation and treatment. Joseph Fletcher attempts to disclose the roots of current Catholic and Jewish theological positions on the

practice of artificial insemination and other non-coital means of achieving pregnancy through a discussion of their underlying presuppositions ot human relationship and the marriage covenant. Recognizing these theological positions is important because they both reflect and shape the emotional attitudes held by persons indirectly influenced through the culture's assimilation of these views, as well as persons directly associated with the religious institutions.

Paul Ramsey and Joseph Fletcher are opposed on nearly every issue. Paul Ramsey speaks out of a traditional understanding of marriage and opposes technology's encroachment into it. His concern is that by venturing to control our very image through genetic and procreative experimentation, we will lose our sense of what it means to be "creatures" organically related to the rest of the created world. Fletcher, on the other hand, is concerned that technology be used to deepen our understandings of our human relationships and responsibilities. The position on which they are in strict agreement, however, is that the claim to a right to parent, or the claim to a right to pass on one's family's genes has absolutely no ethical, social, biological, or religious basis.

Chapter VII

NARROWING ALTERNATIVES

A. INTRODUCTION

Alternatives rapidly narrow for the infertile couple for whom medical treatment is unsuccessful. The legal, ethical, and personal difficulties of each alternative as well as its promise need to be realistically faced by the couple's supportive community as well as by the couple. There are no easy, ready-made solutions. This chapter discusses four currently available alternatives: the use of a surrogate mother, artificial insemination by a donor (AID), adoption, and the choice to become childfree.

B. THE SURROGATE MOTHER

When the husband is fertile but the wife is not able to conceive or carry a child because of her own health, fertility problems, or genetic disease, a small number of couples resort to the use of a "surrogate mother," who is impregnated with the husband's sperm (AID) and who then carries the baby to full term. The infertile couple adopts the child at birth.

Understandably highly controversial, as of this writing surrogate parenting is openly available only in Kentucky, although couples occasionally arrange it independently. The practice can be expected to spread if healthy, adoptable infants become even less available and the number of childless couples rises.

C. AID (ARTIFICIAL INSEMINATION BY DONOR)

If the husband is infertile due to an extremely low sperm count or sperm of poor quality, but the wife is presumed fertile, AID may be used. It may also be an option when there is a serious risk of congenital disease for the husband's biological offspring.

AID is not a twentieth-century innovation. Written accounts of its use in animal husbandry date to fourteenth-century Arabian sources.[1] The first human AID was performed in 1890. Today, AID is becoming an accepted practice. An estimated 15,000 babies are conceived each year by this technique.[2] The figures are probably higher, but records are highly confidential and an accurate accounting is impossible. Most couples keep their AID experience a close secret because of possible social stigma the child might have to suffer and legal uncertainties. Few states have statutes which regulate AID, and there have been cases in which a person conceived by AID was denied recognition as the legally legitimate child of the husband.

To avoid legal snarls a doctor may refer a woman successfully impregnated by AID to an obstetrician who has no knowledge of the AID-conception. At birth the obstetrician automatically fills out the birth certificate with the husband and wife as the parents, and there are never any questions as to who the legal father is. Because of the possible legal questions, as well as fear that knowledge of the AID circumstances would stigmatize the child, most couples keep their AID experience a close secret.

One woman I met met was a special education teacher who loved children and desperately wanted a child of her own. After a sudden and brutal divorce, she decided that she could be involved with a man any time during her life, but, at age 38, her childbearing years were fast drawing to a close. If she were ever going to have a baby, it would have to be soon. She decided to try AID. A friend of hers agreed to be the donor in order to make the venture financially possible. Treatment was eventually successful, and at this writing she is several months pregnant.

Normally, sperm donors are carefully screened at AID clinics. They must have sperm excellent in both quality and quantity, and they are screened for possible venereal infections and hereditary diseases. Donors are matched closely to the husband's ethnic background and appearance. Often the donor will even have his blood type considered, so that the blood type of the resulting child would be one the husband and wife could have produced. The Rh factor is also considered in matching the wife with the donor.

Donors are often students, particularly medical interns. Clinics pay for the semen, but many donors report that they do it primarily for the emotional satisfaction. Although sperm can be frozen, best results are gotten with fresh semen--an hour or two old, which means that the donor has to be close to the hospital and on call during the woman's fertile period. A common practice is to limit the number of successful conceptions by one donor to ten as a guard against eventual inbreeding. Total anonymity is guaranteed both the donor and the recipient.

AID usually takes 3-5 months to achieve conception, which is the time range for coitus timed with ovulation. Three inseminations are done per cycle, at $45-$50 per insemination.[3] The procedure often creates an emotional strain for the woman who has to carefully chart her cycle to determine when ovulation occurs and then get to the hospital or clinic during her fertile time several days in a row. The external strain on the husband may be less obvious, but it can be an enormous psychological step for the husband to enter AID. Men who do choose AID, however, sometimes report that the fact that their wives are able to have the pregnancy experience in spite of their infertility helped to ease the guilt of not being able to give their wives children.

Some physicians have the husband perform the insemination. If this is done in order to say that the baby is the husband's because he impregnated his wife, it is an empty gesture. But if it is done in order for the husband to enact his support, involvement, and commitment to their conceiving, birthing, and parenting a child together by means of AID, it is entirely appropriate.

The advantage of AID is that the couple are able to experience pregnancy, delivery and breastfeeding. In her book, Infertility: A Guide for the Infertile Couple, Barbara Eck Menning points out that one indication of AID's success is the number of parents who return for another baby.

D. ADOPTION

1. Agency Adoption

The traditional and most widely accepted alternative open to infertile couples is adoption. Until the 1970's, adopting a healthy infant of the couple's own race was relatively easy: 75% of all children born out of wedlock were placed for adoption. Now the figure may be as low as 10%.[4] The availability of birth control and abortion are also factors which affect the number of adoptable infants. One of the reasons for the drop in the number of infants available through agency adoption is the agencies' shift in self-understanding and what they perceive to be the most pressing social needs. This shift is primarily the result of the smaller number of babies available, but it has also contributed to the "shortage"; of the women who do place their infants up for adoption, significantly fewer choose to do it through an agency. Agencies now usually concentrate on older children and children with special problems. The director of the Los Angeles County Department of Adoptions states, "The children we are currently placing tend to be over eight years old. They have more serious physical and emotional problems than children placed in the past."[5]

The children who have special needs are children of all races who are difficult to place in suitable homes. They may be school-age children, sibling groups, children with serious medical, emotional or learning disabilities, the mentally retarded, or children who have been abused or neglected. Adoptive homes are always needed for children in

these categories, and often rules and restrictions will be waived in order to make a placement. It is doubtful whether first-time parents should attempt a "special needs" child unless they have had special preparation and/or a continuing support system. Parents need to be skilled, confident, and highly flexible to successfully adopt and parent in this category, qualities which the infertility experience has often temporarily or permanently weakened. In many states, there is a 50% failure rate on these placements,[6] failures which cause irreparable damage to the adoptive parents and children alike.

The safest legal route for adoption is through a licensed child-placing agency. This may be the Department of Adoptions for a state or county, or a private agency such as Children's Home Society. It is the only legal route in Massachusetts, Michigan, Minnesota, Connecticut, and Delaware.[7]

Most agencies require that the age range between a child and the adoptive parents be no more than 35 years. If an adoption process takes three to five years, a couple needs to be not much more than 30 years old when they submit their application! This can shut out infertile couples who delayed parenthood and then did not enter infertility treatment until after age 30.

The adoption process often reactivates the feelings of loss of control and anger over their infertility. Couples often make their first contact with an agency in a time of crisis--they may have just begun to confront their infertility and are in emotional turmoil. They may be receptive to an offer of help to begin sorting out their feelings and coming to terms with the implications of their inability to have

biological children. However, if the agency's worker is not open to help the couple through this time, a great deal of anger can build up. Because the social worker is perceived (correctly) to have the power to give or withold approval for adoption, the couple's anger cannot be openly expressed. It often is turned inward in the form of depression and anxiety.

> In the period before the child is placed with them, adoptive applicants are likely to experience very strong feelings, typically of deprivation, anxiety, sorrow, over-sensitivity, frustration, and perhaps of personal inadequacy. In women, these feelings are likely to be strongly felt and overtly expressed. Men typically express themselves less forcefully, and a good many say they are concerned only because of their wives' feelings.[8]

Too often the adoption worker is either not trained or too overworked to deal with these issues with the couple. S/He may tell the couple to come back in a few months after they have resolved their personal issues. Agencies do not function as advocates for pre-adoptive parents; the supportive services offered their applicants are minimal.

> . . . no one at our agency seemed sympathetic concerning our infertility. No one ever said, "This must be very difficult for you, waiting so long for a child." I was never offered information on infertility or how to cope with the frustrations of waiting.[9]

A further frustration for infertile couples is the considerable control the biological mother can have in determining placement--income range, age of the couple, race, level of education, number of other children in the family, and religion. Kaye Halverson recalls her own experience:

> The common prerequisites were: handy father, artistic and musical mother, good providers, other children in the family, living in the country or city (depending on where the biological mother was from), and, unbelievably to me, <u>reborn</u> Christians. Reborn! It was now not enough that we had been Christians all our lives. <u>Reborn</u> was better. I was bitter, hostile, and angry at the agency for honoring

such requests.[10]

Supportive pastoral care is often much needed during the initial inquiry and later through these years. The assurance that someone knows and cares and is willing to listen is very important. Anger may need to be expressed in an accepting environment. Adoption support groups sponsored by churches or associations of churches could provide a much needed support and advocacy service in many communities for couples and singles considering adoption and for those who are in the process.

2. International Adoption

In some areas, international adoptions outnumber or equal local adoptions. Countries which permit children to be adopted out of the country include South Korea, Colombia, El Salvador, India, Sri Lanka, and Thailand.[11] It is a rewarding experience, but full of red tape and delays.

For agencies like Holt Children's Services, international adoption is only a stopgap measure after all else fails. The first priority is to keep the child with its natural family or in its native country. When that is not possible, a western family is considered. As countries like South Korea raise their standard of living, fewer babies are abandoned because of family disruptions and poverty; as customs slowly change, legal adoption and foster care become possible throughout the society. This is preferable for the moral and spiritual health of the culture as well as for the welfare of children, but it means that international adoption is not always a reliable source for children. Countries "open" and "close" due to increasing social stability as well

as to natural and political disasters! Further, it must be remembered that international adoptions are sometimes an embarrassment to the countries which send children out. For them, it is a bitter public admission of their inability to provide for the welfare of their own people. The adoptions drain away the youth that in better days would have helped to carry on their culture. Adoption "exports" to the U.S., Canada, and Europe are viewed as one more expression of western imperialism, an attitude which certainly must contribute to the uncertainties and delays involved.

The screening and placement process is the same as for a local agency adoption.

3. Independent, or Private Adoption

Eighty percent of all adoptions in the United States are independent adoptions. Usually the intermediary is a lawyer or a doctor. There is no formal home study, although some states require a social worker to investigate the adoptive home. The intermediary charges "reasonable" fees (from $1,000), and the adopting couple pay the mother's medical expenses. Anonymity is not always preserved. The wait may be as short as a few months, but the biological mother or father is able to reclaim the child for a period of time after placement.

Some lawyers and social workers advocate that couples find their own babies by analyzing and utilizing their individual social networks. This usually means meeting the mother face-to-face and working out an arrangement, with a lawyer to finalize the legal work. Reports are that couples are locating babies within 3-5 months, sometimes with very

little expense if the mother does not need reimbursement for medical care. The professionals who advocate this method argue that the adoption agencies do not serve the needs of the biological mothers, so women are not going to them for help. Consequently, agencies do not have babies to place. (The agencies do not pay maternity hospital costs, a major consideration for some women.) Opponents argue that there is little protection for any of the parties involved, especially the infant. Rules of free and open enterprise should not apply to adoption. As mentioned above, five states prohibit private adoptions.

4. Infertility and Adoption

Rather than easing a marital or personal strain, adoption, because it is a major life-change event, often exacerbates it. Doctors and other community workers sometimes mistakenly help a couple to find a baby to adopt in order to save their marriage, only to find divorce a reality before the adoption is completed. The divorce rate seems to be even higher for couples who have adopted within a year than for the general population.

Adoption is not an easy process, and it is not a cure for infertility. Whether infertile couples who adopt conceive more often than couples who do not is debatable. There is some argument that the adoption experience leads to a better state of mind and a higher level of confidence which can affect the fertility level, but this has not been conclusively shown to be the case. Generally, the consensus seems to be that the cure rate for infertile adoptive couples is 5%--the spontaneous recovery rate. Adoption cures childlessness, but it does

not erase the infertility experience:

> Adoption eased the pain of childlessness, but one fact is irrevocable. I will never be able to experience a pregnancy. I will never be able to reproduce those genes I find so adorable in my husband. Adoption does not cure infertility.[12]

How well the adoption adjustments are made will in large part depend upon how the couple come to interpret their infertility. Infertile persons are in a dynamic grief and resolution process. Glib reassurance ("You'll love an adopted child just as much as if it were your own") does not help. According to David and Ruth Kirk,

> Infertile adopters must be taught that facing their own pain over their infertility and/or childlessness will make them better able to feel with, to have empathy with their adopted child. Having learned to face their pain and deal constructively with it, and remembering what it is like to FEEL pain, they can better understand their child's pain over being relinquished, and his need to understand.[13]

For most families, adoption is an exciting, life-changing commitment. Parental love is not determined by biology, but established through commitment. Mother and father love, whether for a biological or an adopted child, grows out of the day-to-day relationship based upon care and trust. Adoptive parents often see "family traits" appearing in their child. Behavior patterns--and even appearance--they had thought were due to family "genes" to a large extent were instead habits shaped by the family environment, and those qualities, they now see to their delight, are indeed being passed on to the adopted child. The Old Testament phrase for adoption, "to be born on the knees" of the mother and father, is indeed apt.

E. CHILDFREE LIVING

An option to every childless couple and, to a lesser extent, to the single-child couple, is to decide to remain without children. "Childless" carries negative connotations and implies an involuntary status. "Childfree" emphasizes that the choice has been made to remain without children in order to follow personally meaningful pursuits. It does not mean that children as persons are undesirable. Significant relationships with children can be made through channels other than parenting--teaching, volunteer work, providing foster care, perhaps being an unofficial "aunt" or "uncle" for children and youth in the church and neighborhood. These relationships are not substitutes for the parenting role, but are potentially rich and rewarding for both the adult and the young person in their own right. Educators and sociologists emphasize the importance of "significant others" for the healthy personality development of children and youth.

There are a variety of reasons why a couple who have tried to get pregnant might make the childfree decision. Perhaps the years of prioritizing personal and career decisions around the possibility of a child have taken a greater toll than the couple had realized, and they decide it is time to begin making new plans which would not readily adapt to children. Perhaps the natural time line the couple was working with has expired. There was a time for children, but it has passed. Often the wife's age is the major consideration, but vocational interests are also factors. Or, perhaps the couple objectively re-evaluate their commitment to parenting and find that they have been trying to get pregnant more to satisfy the expectations of others than

their own needs.

Couples who decide to remain childfree usually opt for a return to birth control or permanent sterilization, so no more energy is spent thinking about the possibility of an unexpected pregnancy. They report feelings of increased self-esteem, confidence, creativity, and self-satisfaction after making this decision.

Chapter VIII

THE DYNAMICS OF CRISIS AND INFERTILITY

A. INTRODUCTION

Infertility represents a chronic physical condition, but the intense emotional struggle with infertility is relatively brief and acute. While emotional stress continues, and feelings of grief and loss will recur, perhaps for years, intense turmoil is usually resolved within two or three months. However, a delayed menstrual period, miscarriage, or a major trauma such as surgery will easily reopen the grief wound and can precipitate another crisis which complicates the emotional resolution of infertility further. Most professionals--physicians, adoption workers, and counselors--first meet infertile couples during a crisis time.[1] It is important that the nature and the dynamics of this emotionally critical period be understood so that it can be recognized and appropriately responded to.

B. CRISIS DEFINED

Everyone is constantly faced with situations demanding problem-solving activities. When familiar skills are adequate for solving a particular problem, the tension caused by the problem is quickly released. An emotional crisis occurs when all of the individual's usual problem-solving skills are either blocked or ineffective. Typical of a crisis response, a common frustration expressed by infertile persons is that they cannot <u>do</u> anything to change

their infertility. They are powerless to control their own destiny.

> Never have I met a barrier I couldn't actively deal with. If it meant studying more or tackling harder, there was something I could do to improve myself. Work harder! Work longer! Eventually all succumbed.[2]

An individual or a couple experience emotional crisis when a problem is perceived to be a serious threat to important life goals. The loss of potential motherhood or fatherhood, for example, may seriously threaten important adult-identity concepts.

Although crises are a normal part of human life and growth, they need to be viewed with seriousness because mental health and adaptability often hang in the balance. The crisis is a point of decision, a turning point toward or away from health and wholeness. One does not emerge from crisis unchanged. Caplan writes:

> the new pattern of coping that he works out in dealing with the crisis becomes thence forward an integral part of his problem-solving responses and increases the chance that he will deal more or less realistically with future hazards.[3]

C. TYPES OF CRISES

There are two kinds of crises: developmental and situational. Growth takes place when they are met and successfully resolved. A partial list of developmental crises includes birth, weaning, puberty, going to school, choosing a vocation, marriage, pregnancy, middle-age crisis, and facing one's own death. Situational crises are precipitated by an abnormal, unexpected loss or need-blockage: the loss of a job or a position of status and respect, an incapacitating accident or illness, the death of a child, alcoholism, natural disaster, divoce, unwanted pregnancy. Any of these events produces an "emotionally hazardous

situation"[4] which can precipitate an emotional crisis. A "precipitating event" such as infertility may cause a crisis for one couple and not for another. Whether a crisis occurs, and how serious it is depends upon the value they place upon having a baby, and the effectiveness of the couple's emotional mechanisms for coping with the loss threatened by their infertility.

Infertility primarily represents a situational crisis in that it involves an abnormal and unexpected loss of an important life goal. However, a developmental crisis may be complicated if adult "generativity needs" are not met. "Generativity" is a term originated by Erik Erikson. It is associated with, but is not identical to, the birthing and parenting of children. Erik Erikson stresses the necessity of "generativity" for the development of a healthy, integrated adult personality. The more closely persons identify the satisfaction of their generativity needs with biological parenting, the more the situational crisis precipitated by infertility will take on the character of a developmental crisis. Erikson's definition is worth quoting at length:

> Sexual mates who find, or are on their way to finding, true genitality in their relations will soon wish (if, indeed, developments wait for the express wish) to combine their personalities and energies in the production and care of common offspring. The pervasive development underlying this wish I have termed <u>generativity</u>, because it concerns the establishment (by way of genitality and genes) of the next generation. No other fashionable term, such as creativity or productivity, seems to me to convey the necessary idea. Generativity is primarily the interest in establishing and guiding the next generation, although there are people who, from misfortune or because of special and genuine gifts in other directions, do not apply this drive to offspring but to other forms of altruistic concern and of creativity, which may absorb their kind of parental responsibility. The principal thing is to realize that this is a stage of the growth of the healthy

> personality and that where such enrichment fails altogether, regression from generativity to an obsessive need for pseudo intimacy takes place, often with a pervading sense of stagnation and interpersonal impoverishment.[5]

Erikson stresses that "the mere fact of having or even wanting children" does not necessarily indicate generativity. He contends that a majority of young parents seen in child-guidance work suffer from the inability to develop generativity. One of the reasons for this is "the lack of some faith, some 'belief in the species,' which would make a child appear to be a welcome trust of the community."[6]

Whether situational or developmental, a crisis is a period of intense emotional disequilibrium. It is associated with a rise in anxiety and tension, the experiencing of unpleasant feelings, and disorganization of usual functioning. The infertile couple in crisis are extremely vulnerable. Because of their temporary personality disorganization, their emotional resources for helping and supporting one another are inadequate at this time. They are especially sensitive to the real or imagined indifference of professionals, family, friends, and peers. Misinformed advice and platitudes hurt, and often couples remember them with anger years later.

Howard Stone points out that a crisis is essentially religious in nature, because it involves issues one must come to terms with if life is to be fulfilling.

> The person in crisis is one who has begun to lose perspective, feel anxious and helpless, often depressed and worthless, frequently without hope, whose future seems to be blocked out, who even has lost sight of some of his own past. Faith . . . is a direct counterforce to the dynamics of crisis.[7]

Counseling which deals only with the emotional, physical, or intellectual aspects of a couple's infertility crisis, ignoring the

spiritual and "meaning" dimensions, does not respond to their total needs. Infertile persons in crisis are especially receptive to religious values and meanings if they are sensitively offered.

D. CRISIS BEHAVIOR

A person in crisis displays characteristic behavior, which may include sighing a lot, frequent uncontrollable crying, and exhaustion. The person may express feelings of helplessness and inadequacy, difficulty concentrating and making decisions, an overwhelming sense of isolation, and a sense of chaos and confusion in personal, professional, and social relationships. During infertility crises, these behaviors are more often expected and seen in women than in men. In terms of family dynamics, the woman may be expressing the emotional state for both herself and her husband.

> I cried almost uncontrollably at almost anything: a pregnant woman walking down the street, a friend announcing her pregnancy. . . . I felt pitied, atypical, and extremely vulnerable. . . . Although I loved being a homemaker, I felt unsuccessful because we had no children. I pictured myself a failure, an inadequate, unfulfilled woman. I began to dislike teaching and became irritable with the children. Now I was a failure at my job, too. I lost all confidence in myself and went in and out of deep depressions. I coped publicly, but privately I fell apart. . . . I could no longer deny to myself that I was infertile, but I dreaded anyone else finding out, so I isolated myself from friends and even from family.[8]

These behaviors are not signs of mental illness; they are the person's normal reactions to an emotionally hazardous situation. Unfortunately, when the precipitator of the crisis is primarily an emotional loss (divorce, death of a loved one) rather than a physical loss (an amputation, stroke, heart attack), there tends to be a stigma

attached to the person's changed behavior.[9] This may be one reason why many infertile persons seem to need to limit their perception of the problem to the medical dimension; perhaps it is self-defense in the face of friends' and relatives' disapproval of their behavior.

> It seems silly that anyone would want something so badly that they would grieve at not getting it. How can a person mourn the loss of what one never had? I can't understand that reaction at all.
>
> I'm afraid I haven't been a very good friend for Suzanne. I can't understand why her infertility should be such a problem. She has a great relationship with her husband Marty, a wonderful little girl, and a brilliant mind. I don't understand why that isn't enough. It really upsets me to see how much her infertility hurts her, makes it hard for her to be with others. I guess I haven't been supportive at all. I just want her to get herself together and get on with life.

E. DANGER SIGNS

Indications that the person or the family system is not constructively dealing with infertility include the following:

1. The denial that their infertility is a medical problem
2. The refusal to seek or to accept medical and/or counseling help
3. An inability to express or to master negative feelings.
4. Failure to explore the nature of their reactions to infertility
5. Failure to explore alternative solutions.
6. Projection onto others of total responsibility for causing and/or curing the infertility and the problems caused by it.[10]
7. Turning away from friends and family.

Short-term crisis counseling can be a major help if it steers the person away from maladaptive responses to a constructive facing of the problem.

> If the individual . . . can be helped to face the problem and cope with it in a healthy way, there is usually no need for the counselor to attempt the difficult, time-consuming process of searching for the underlying reasons for the initial maladaptive response.[11]

F. SIGNS OF RESOLUTION

Positive signs that the infertility crisis is being resolved in a healthy, reality-affirming manner include:

1. Facing infertility as an emotional and physical/medical problem.
2. Enlarging one's understanding of it.
3. Expressing and working through negative feelings.
4. Accepting responsibility for coping with the problem.
5. Exploring alternatives.
6. Identifying what is changeable and what is unchangeable, and accepting the difference.
7. Opening channels of communication with other helping persons among relatives, friends, and professional persons.
8. Taking steps, however small, to handle the problem constructively.[12]

F. SURRENDER

> I don't know what changed. Actually, nothing changed. I changed. I'd been so caught up in treatments, in whether I could get the drug I needed to start my ovulation, in whether it would work this time. One day I realized I wasn't happy, and that my life was too short, too precious to be spent being unhappy. I knew that no one else could make me be happy. I had to take responsibility for my own happiness--whatever happened. Things have never been the same. All I can say is, it was a conversion experience.

Psychiatrist Harry Tiebout identified the phenomenon of "emotional surrender" and its importance for the treatment and recovery of alcoholics. Since then, the phenomenon has been recognized as a crisis-resolution experience. The experience is characterized by a powerful perception of one's own humanity and a turn to "cooperate with life." It occurs "at a deep, nonvolitional level of the psyche, suddenly or gradually."[13] Howard Clinebell proposes that because of the impasse reached during crisis, the old self-destructive defenses simply stop functioning.

"Surrender" does not mean that the person gives up. Instead, she/he turns away from a reality-denying orientation toward a positive stance which is more in tune with reality. It is a powerful experience of healing grace breaking into one's life.

Chapter IX

THE GRIEF EXPERIENCE

A. INTRODUCTION

Perhaps more than any other professional, the minister has extensive and extended personal contact with persons who have suffered significant losses. Understanding the process of grief, and how best to be supportive to those involved is a major concern of ministry. The gradual resolution of infertility is a grief process. Identifying the emotional dynamics which are potentially or actually involved is essential to formulating a general plan of counseling and care for infertile couples.

B. GRIEF DEFINED

The couple who are not able to have a child, or to have as many children as they want are a couple who have suffered a loss. An infertile couple with one or two children who have always planned on three or four may react as strongly as a childless couple to their limited fertility. For example, a woman with two children married a man with one child. Even with three children in the household, their inability to conceive a child <u>together</u> was a bitter pill. They perceived themselves as a childless couple even though they had good relationships with their children born of previous marriages. In many cases, the lack of children is not the problem as much as the lack of <u>ability</u> to conceive them. Thus, how the loss is <u>perceived</u> emotionally

is more important than the concrete physical nature of the loss.

William Rogers made a careful distinction between loss (bereavement) and the response to it (grief). Although his reference was specifically to the loss of a loved one through death, his observation is relevant to grief triggered by other significant emotional losses such as infertility.

> (Grief is) the result of what happens to the bereaved. Something of great importance to the individual, something that is a part of his psychic life, has been torn out, leaving a great pain, the emotion which we call grief.[1]

C. NORMAL STAGES OF GRIEF[2]

1. Denial

Renowned for her work on the stages of grief, Dr. Elisabeth Kubler-Ross believes that initial denial is a healthy response which enables a person to deal with an unpleasant reality. It allows time for the person to collect himself or herself and begin to mobilize emotional resources. The length of time a person spends at this stage depends upon the individual and the nature of the shock received.

Denial is most obvious in infertility cases where a sudden diagnosis of irreversible infertility is made, for example, when a woman has to have a hysterectomy before she has had the children she wants, or when a man recives word from the laboratory that he is absolutely without sperm (azoospermia). Infertility-related traumas such as miscarriage, tubal pregnancy, and stillbirth clearly involve shock and initial denial. The person's response is an unequivocal "NO!"

> My husband's sperm count was very low; we were both crushed. I don't think my husband believed it was actually happening. In fact

> he often talked in the third person, not truly accepting the results.[3]
>
> ---
>
> It was wonderful to finally be pregnant. We were both elated. Then, about a week later, I began to spot. We reassured ourselves it was implantation bleeding. But it didn't stop. After a week the "spotting" was as much as a period and bright red. We still thought it was implantation, although we both knew the signs were miscarriage. After all the time it took to get pregnant, we couldn't believe it. It just wasn't right. After the doctor confirmed the miscarriage I went home and cried hard for a long time. Looking back, I can't believe how we were able to deceive ourselves.

Denial may lead a couple to stop trying to get pregnant before they have to admit infertility. They may rationalize month after month after month of conception failure: Tom was tired out from his trip; Mary was under family stress; we must have just missed the right day, and so on. Each month brings fresh hope and an unwillingness to admit the problem:

> I have a regular cycle and I know what part of it I'm in all the time. And from the second week on, I knew that I was pregnant--every month. If I didn't feel very good, or if I'd drunk a lot and had to go to the bathroom very often, I'd immediately think, "Aha! I'm pregnant." Then I acted and took care of myself as if I were pregnant. And then I'd start my period.

2. Isolation

Isolation is the feeling that "no one else has felt the pain I feel," that no one understands, that no one cares. It develops very easily if a couple does not tell anyone that they are trying to get pregnant. Friends and family may assume the couple is using birth control and start teasing and pressuring them about starting a family. The teasing is painful, causing the couple to confide even less, and then withdraw more. The social support system may begin to break down when it is most needed.

Unfortunately, if the couple do confide in friends and family, they may open themselves to unwelcome, if well-intentioned, advice, which further increases the feelings of isolation.

> I got so that if one more person came up to me and said, "Relax, don't try so hard," I'd have slugged them in the face! I get so frustrated with comments like "you're trying too hard." How could I try hard to not try hard? And the stories about people adopting children and then having their own baby right after. Oh, that used to burn me! The other thing people would say is, "Take a vacation." I couldn't figure out how taking a vacation was going to change anything.
>
> ---
>
> Several different women told me in all seriousness that I wasn't getting pregnant because I'd saved get all our child's baby clothes. They really believed if I'd give them away, I'd get pregnant.
>
> ---
>
> Ginny has a couple of friends at work she can talk with, but none of my friends know about it. It's not a macho thing--I'd just never think of bringing up the subject. I don't think they'd be able to understand, and it would just make everyone uncomfortable.

Isolation sometimes invades the marriage relationship itself, and causes the couple to draw further apart rather than closer together. Even though infertility is a shared problem, it is still extremely individual and personal. The husband, because he is a man, will never know the shattering emptiness of his wife's period. She, because she is a woman, cannot experience the threat that sex-on-schedule can create for her husband, or know what it is like to be subject to the rhythms of another's body cycle. They may feel angry toward each other, feeling their spouse has let them down when they most needed understanding and support.

Several men and women reported that their first response upon learning that the physical problem rested with them rather than with their spouse was to offer him/her a divorce so that he/she could have children with someone else.

3. Anger

"Why us?" Announcements of baby showers evoke both envy and rage: "It should have been my turn!" "It's not fair!" News articles reporting child abuse or neglect are excruciating. "We would be wonderful parents if we had the chance. Then someone like this has no trouble having lots of kids. It's just not fair!"

God as the universe's ultimate authority figure is an object of anger--directly or indirectly expressed. The anger may not be articulated unless the counselor opens the subject and encourages expression.

> I guess God knew if I had a baby it would be the center of my life--my idol. God is a jealous God. He knows my heart, and he knows I barely have room for him now. He's not giving me a baby because he wants me for himself.
>
> ---
>
> There is no God. If there were a God, he wouldn't do a thing like this. If there were a God and he did do this, I could never worship him.
>
> ---
>
> Yes, I'm mad. I think I'm angry with God, which is ridiculous because I'm not a believer.

Friends and family are frequently objects of anger:

> I think I had a right to expect more from my friends. I don't expect them to say, "Cool it, no more kid talk--here comes Dorothy. But they never talk about anything else <u>except</u> pregnancies and kids. They simply have no conception how much it hurts.

One husband reported that he directed anger to the child--the stubborn child who refused to come.

> There already was a child, it was somehow just a matter of <u>conceiving</u> it, of invoking its presence and reality. In a strange way, I felt I already knew this child. When my wife's period would come, I felt angry with that obstinate child and frustrated that I had no power over it.

4. Bargaining

Persons under intense emotional stress revert, temporarily or permanently, to a magical world view. Bargaining is an attempt to regain control of one's life in an "out of control" situation. There are powers in the world one cannot control, but perhaps if they cannot be controlled they can at least be gotten onto one's side.

> I guess I'd decided--not consciously of course--that I wasn't having a baby because God didn't think I deserved one. About the second week of every month I became Super Mom. I think now I believed that if I were a good mother to Joey, God would see my good behavior and find me worthy of another child.
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> ---
>
> I became a Catholic because I thought that's what God wanted and it would help. I was extra nice to people, thinking all the time, "See, Lord, I'm really a nice person."
>
> ---
>
> While we were in Hawaii, I bought two fertility goddesses made of lava rock and put one on his side of the bed, and one on my side. I wasn't really serious, but after a couple of weeks, I was really depressed and I picked them up and threw them in a drawer and haven't taken them out since.

5. Guilt

Completely separate from the rational, scientific medical diagnosis, many couples have a suspicion as to the cause of their problem. A number of couples were asked the following question: "Do you have an idea--perhaps one which wouldn't wash with your doctor or anyone else, perhaps an idea you don't really believe yourself--as to why you're not able to have a baby?" Regardless of their stage in infertility work, their religious affiliation, or their educational level, every person responded with a smile, a brief pause, and an "existential diagnosis." The reasons almost always involved incidents

or life-patterns which left feelings of guilt and anxiety. These "existential diagnoses" may be of real significance in the therapeutic treatment of infertility, since sometimes they may identify an unresolved emotional issue which is affecting the couple's fertility or its emotional resolution.

> Carl and Judy became pregnant before marriage and under family pressure agreed to have an abortion. Several year later, married, they sought to have a child. The medical diagnosis revealed that Judy was irreversibly infertile due to damage caused by the abortion. In counseling, their minister suggested adoption. Judy burst out in anguish, "I don't deserve to have a baby . . . ever! And (to her husband) neither do you!"[4]
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> ---
>
> I think there's a certain guilt on my part that maybe I'm not having a child because I've chosen to ignore God and I've stopped going to church. If that's the case, then that's not an all-loving God, but I have the fear that that might be the case. But because I haven't been religious in years . . . I would feel selfish if I prayed for this for me if I haven't prayed for the needs of other people.
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> ---
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> All kinds of things started coming in on me. I had guilt because I'd had sex before I was married with Wes. I'd had other relationships. I remembered telling my first boyfriend, "I don't want to have anyone's baby but yours." That was my way to latch onto him. I felt a lot of guilt about that. There were a couple other relationships, where I'd prayed, "Lord, I can't be pregnant!" I thought, "Well, how many times did I pray that? How many times since then have I prayed to be pregnant?" I knew that my prayers to be pregnant outnumbered my prayers not to be pregnant. I tried to balance things out.
>
> ---
>
> I'm sterile because of V.D. I guess I feel like I'm being punished twice. Not only can't I have a kid to carry on my name, but my wife will never have the pregnancy she wants so bad. And, it's my fault. Getting V.D. is not like totalling a motorcycle and getting injured and permanently damaged. This really is my fault. I never forget that.
>
> ---
>
> We both know better, but I guess we have this feeling that we're being punished by these miscarriages, and that if we push on with treatment and have a baby we'll really get punished--by God, Nature, Fate, whatever. Maybe we're not getting pregnant because there's something wrong with us and we can't have a normal baby. I can handle not having a baby, but I can't cope with the thought of a retarded or seriously handicapped child. The underlying fear that we're going against God's will that we not have a child is pretty

strong. We'll keep trying, but those feelings are there.

Working through guilt is a normal and healthy part of mourning, but the counselor should not overlook the possibility that in some cases a man or woman's guilt might be a psychological factor contributing to infertility, rather than a direct result of the infertility experience. Reassurance is rarely effective; confession and forgiveness, expressed and experienced in any of a variety of ways--prayer, counseling, the liturgy of public worship, or "talking it out" with an understanding friend or spouse--are the healing forces at this point.

6. Depression

During this time the couple mourn the loss of their child, and the futility of medical treatment. Tears, listlessness, inability to sleep well, lack of interest in doing anything, irritability, lack of interest in sex and self-destructive behavior ranging from overeating or overworking to the extreme of suicide indicate depression. It is normal for the infertile person to project emotions onto body image. Bodies become "ugly," "empty," "numb," "neuter," "ripped up," and "ineffectual." The person feels alienated from his/her body, and trapped by it. A medical term, which refers only to a particular infertility condition, "hostile womb," accurately reflects many an infertile woman's image of herself and her sexuality.

Severe or chronic depression requires professional intervention. Much has been written concerning the effects the stress of obligatory sex-on-schedule can have on a couple's sex life. It is generally identified as the source of sexual problems--after several months, the

couple just cannot "perform" anymore. But usually it is not only during the fertile week that the couple can't face the thought of having to make love; intercourse becomes very difficult all the time. It may be that decreased sexual appetite at this time is symptomatic of depression--the loss of hope that any of this makes any difference. Couples who revert to birth control when the pressure gets too intense, or who decide to remain childless commonly report that they rediscover the joy of sex. Is this because they are released from their schedule? Or is it, rather, the result of increased internality and personal satisfacton from exercising control over their lives?

7. Acceptance

One's awareness of infertility never really disappears, but eventually it can and must be accepted and lived with. The experience of surrender discussed in the previous chapter is often one aspect of this stage.

> I went to the doctor with a bad cold. He said, "You're probably pregnant." And the most wonderful thing happened. The thought was there--maybe, just maybe, I am pregnant. But it didn't overwhelm me. The desire didn't have hold anymore. I was in control of my emotions. I was in complete control. That felt wonderful.

D. THE QUEST FOR CERTAINTY

Uncertainty cannot continue forever. At some point, infertile persons experience an intense desire to have the uncertainty ended, one way or another. This quest for certainty can be as intense as the drive to have a child.

> At that point all I wanted was for someone to say either, "Yes, Karen, you can have a child," or "No, Karen, you can't have a child." If it was "No," then I could say, "O.K., then forget it," and continue my life.
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> ---
>
> Everything I do, every decision I make is predicated around having a baby. It drives Bill up the wall. For example, the spare room is the Baby's Room. When we got another couch, I talked Bill into putting it into the Baby's Room so that I could lie down while the baby was napping. Later, Bill wanted to book a cruise, but we went to Hawaii instead because a cruise has to be booked a year and a half in advance and I was afraid that I would be six months pregnant and not feel like being out on the ocean. Everything is weighed in the expectation of a baby. I think if a doctor sat down and told me, "Ann, you'll never have a baby. It's impossible," I would be crushed. I would cry. I'd be terribly hurt. But I'd recover. And I'd actually be very relieved, because I'd finally feel that we were free and could pursue other things. We'd know we'd done everything we could. We'd adopt tomorrow if we knew we couldn't have a baby, but we don't want to adopt while there's still hope. In a way, hope is the hardest thing to live with. If the last piece of hope could be wiped out, I'd feel much more relaxed and free.

An infertility investigation can be therapeutic regardless of whether or not a definite diagnosis is made if it releases the couple for other pursuits. As one husband thoughtfully remarked,

> If we take all the tests and there's nothing wrong with us, then at least we'd know that we'd tried, and if we didn't do that, we'd go through our lives knowing we didn't try to do what we could do about our problem. That would make us feel very bad. This is a definite thing that we can do, and when we're done with it, I know we will feel a lot better.

Chapter X

THE INFERTILITY GROWTH GROUP

A. INTRODUCTION

An infertility growth group under the guidance of a skilled minister or counsellor can play a vital therapeutic role in the physical as well as spiritual/emotional recovery and growth of infertile persons. Being able to share freely with others who are infertile is an important factor in coming to accept one's infertility and one's feelings about it. As helpful and as necessary as individual counseling sessions are for some couples the social context of the group is an effective means of breaking down or preventing isolation which often develops.

Relatively few people have adequate sustaining and nurturing social networks. When a couple's network is flimsy or non-existent, they are vulnerable to any emotionally threatening situation. One task of the Christian community is to provide resources and an environment in which nurturing networks can develop. People who have difficulty resolving their infertility grief work tend to be persons without strong and dependable social networks. Persons who feel assured of their acceptance and worth as persons by their friends and extended family have more emotional resources to draw upon during the infertility crisis and/or grief period, and have a far better chance of successfully working through the emotional issues than those who lack this assurance.

A meeting of infertile persons may provide the first opportunity many have had to "tell their stories" to others who are listening to more than the medical issues, and who are listening with empathy and understanding. Personal catharsis is important, but at the same time, the act of also listening to others helps to begin to develop some emotional distance and a clearer perspective on the problem. The group may represent the only emotionally safe gathering infertile persons have during times when they are feeling especially vulnerable. It can be an important source of fellowship and Christian nurture for those who want to share and explore their experience with others, as well as for those who feel that no one really understands or cares what they have been going through. Remarks from two group participants--one male, one female--illustrate this:

> I always thought I was the only one who felt this way! It really helps to know some of you have gone through this stuff, and it's not just me.
>
> ---
>
> I've felt like I looked as wierd on the outside as I Feel on the inside. I didn't know who was going to be here tonight--maybe some wierd people. It was so neat to walk in and see all of you looking so <u>normal</u>!

An infertility group needs to look beyond initial venting, initial catharsis, and initial infertility information to issues of personal and spiritual growth and vitality. The central concern is not making time bearable until a baby is born or adopted, or until the couple finally gives up. Rather, the central concern is the formation of a strong and integrated adult identity and an enhanced marriage relationship. Emphasis on growth is essential. An undirected group without an explicit "growth" orientation implicitly encourages an

expectation of a return to normal.

But there will be no return to "normal" as each person once defined it. With or without children, persons who have known infertility can never view their lives or their bodies as they once did. A covenanted growth group commits itself to openness to God's directivity in the lives of its members, for it is in spiritual growth and openness that health and wholeness lie.

B. ORGANIZATION

It is highly desirable that every married member will attend with his/her spouse, but it is not likely that every spouse will be able or willing to attend. However, clear signals should be given verbally and in written publicity that, if at all possible, both members of each couple are expected to join. Groups tend to have more attending wives than husbands, sometimes due to male resistance to admitting infertility complicity ("She wants a baby, she's not getting pregnant--I figure it's her problem"), but just as frequently due to female exclusivity ("I thought it would be best it we girls had a chance to talk and then maybe I'd invite him to the next meeting"). Regular attendance needs to be a requirement for continued membership. Because the group's purpose is for "spiritual growth and fellowship," it needs to meet once a week rather than once or twice a month in order to build a bond of trust and friendship among the members. Nine to twelve months should be the group's maximum life expectancy and members then need to be encouraged to join another type of fellowship group. Group size should range between six to twelve individuals.

Whether there should be a fee for meetings debatable. It is certainly reasonable to charge in order to pay for a counselor, rent, or materials, or if it is a congregation's policy to charge tuition or membership fees for adult classes or fellowship groups. However, the current trend toward charging fees solely to assure commitment is questionable. Money is neither the most appropriate nor the most effective means of creating group loyalty. Time is usually more valuable than money; personal commitment more costly. Group loyalty develops in a covenanted relationship when a person becomes a contributing member of the group, feeling needed and wanted, identifying the goals and values of the group as his/her own. The commitment of every member to every other member is an essential factor to the group's effectiveness, but "individual therapy" fees can actually undermine this type of mutual commitment.

Another organizational question arises in regard to members who get pregnant or adopt. It needs to be clearly understood by every member at the beginning that membership continues regardless of their medical progress. This is important for several reasons: (1) if the group becomes a significant source of fellowship and support and potential pregnancy threatens the loss of that nurture, the group may actually become a factor in continued failure to conceive; (2) infertile couples who conceive are at a higher risk of miscarriage than couples who had no difficulty conceiving; and (3) pregnancy--no matter how greatly desired--<u>increases</u> rather than decreases stress levels.

Organizing relevant group agenda will depend upon analyzing the issues of infertility--personal, social, religious/meaning, ethical,

medical and psychological--and then determining how they will best be dealt with in a particular group in relationship to the members' felt needs.

C. INFORMATION AND EDUCATION

The value of information dissemination should not be underestimated. A study book for discussion (see Appendix I) could be very useful. An article on a topic of interest could be given out to be read at home and discussed the next week. A selection of books and articles dealing with personal and marital growth topics as well as infertility needs to be available for home use.

Infertility information and education should not be limited to its medical aspects. The dynamics of crisis and grief need to be addressed in at least one lecture/discussion session with the purpose of identifying analogous developmental or situational crises people experience during their lives. A knowledge of the emotional dynamics of crisis and grief and how they relate to infertility as well as to other life events can help infertile persons to understand and accept their feelings as both normal and necessary for an authentic emotional resolution.

D. THE MEANINGS OF INFERTILITY

"Children," "babies," "family," and "pregnancy" are words which mean different things to different people. The leader needs to help the group members identify what the object of their desire (getting pregnant, having a baby, starting a family) means to them on a deeper

level: the continuation of a family line, the confirmation of femininity/masculinity, an outward sign of an inner bond between the husband and wife, the resolution or expression of the extended family's adults' relationships with the children in their midst, having someone who will not reject love, the experience of helping to guide and shape a developing person, and so forth.

Because fertility means something different to each man and woman, the meaning and impact of infertility is different for each. Of course there are universal patterns, but the experience and its internally-ordered meaning is unique to every person. Until persons are able to discover the meanings they invest in their fertility, they will not be effective in interpreting or transcending their infertility. A positive response will vary according to what the meaning of fertility is for a particular person.

E. "CONTROL" VS. "NO CONTROL" ISSUES

At some point, infertile couples generally suffer a loss of self-esteem and internality. They feel little or no control over the outcome of a problem they have identified to be bound up with their emotional well-being. A sense of internality begins to return when the person is able to distinguish areas of his/her life which can be controlled from those which cannot. For this reason, the counselor (and the group) needs to be alert during discussion and sharing times to "control" and "no control" issues when they arise. Emphasis needs to be placed on encouraging members to identify the problems they can control and to spend their energy working on those. For example, the individual

can not do much to change a physical condition which is preventing conception, but a couple can do quite a bit to work out tactics to prevent the first day of the woman's period from being an emotional bombshell between them month after month. The study of options as a group through freewheeling brainstorming and then the thoughtful examination of the possible implications of each suggestion has an important function ot modeling option-exploration behavior for persons who may have lost sight of possible freedom-giving alternatives within their grasp.

F. STRESS MANAGEMENT

Stress management needs to be given high priority since stress can both result from infertility and contribute to it. Stress diminishes the quality of personal and interpersonal relationships and the enjoyment ot life, and needs to be addressed as an issue in its own right. Largely as a result of stress, infertile persons frequently experience alienation from their bodies. The body comes to be seen as an obstacle one must overcome, an enemy to be defeated, therefore any experience of reconcilation and release toward self acceptance will include the body. In a group context, this can involve the skillful use of relaxation exercises and guided imagery. The focus should be on mental and physical relaxation, and on evoking positive mental images. After a sense ot group intimacy has begun to develop, group exercises and games--especially those which involve physical contact and mutual trust among the participants--can radically heighten the trust level and provide strong and emotionally satisfying experiences. If a meeting is

scheduled for two hours, twenty minutes could be well spent on meditation, relaxation, or body awareness exercises.

G. RITUAL RHYTHMS AND PATTERNS

Rituals articulate life's rhythms with a depth and power words alone cannot convey. Several "ritual patterns" need to be part of the group's life together. The term "patterns" is used because the rituals will usually not be formalized. Patterns of prayer will be found in individual and group meditation and imagery times; confession-forgiveness in the sharing of guilt, anger, and feelings of doubt and failure when they are received and responded to with verbal or physical expressions of loving concern. Coffee time is important for enacting the group's commitment to nourish and nurture one another. The group may wish to develop its own rituals to give special significance to those events with special significance: a couple's decision to pursue adoption; a decision to continue treatment through surgery; a career decision previously blocked by uncertainty created by infertility; the first or last meeting, and so on.

Group trust level will have to be very high before this type of depth sharing is either possible or comfortable, and this can take a long time. But it is at this point that the members become a Christian growth group capable of being a healing fellowship.

APPENDICES

APPENDIX I

PUBLISHED RESOURCES

The following books are recommended as basic resources for infertile couples and their ministers. If they are not readily available through the local library system, they should be part of the church library.

ADOPTION

Anderson, David C. Children of Special Value. New York: St. Martins Press, 1971. (A study of children with special needs)

Berman, Claire. We Take This Child. New York: Doubleday, 1974.

Klibanoff, Susan, and Elton Klibanoff. Let's Talk About Adoption. Boston: Little, Brown, 1973.

Kramer, Betty (ed.) The Unbroken Circle, 1975. (Deals with international and interracial adoption. Available from OURS, 3148 Humboldt Avenue, South, Minneapolis, MN 55408. $5.75)

MacNamera, Joan. The Adoption Advisor. New York: Hawthorne Books, 1975. (Includes a comprehensive directory of available resources in the United States)

CHILDFREE LIVING

Whelan, Elizabeth M. A Baby? . . . Maybe. New York: Bobbs-Merrill, 1975.

INFERTILITY

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APPENDIX II

ORGANIZATIONAL RESOURCES

ADOPTION

Adoption Resource Exchange of North America (ARENA), 67 Irving Place, New York, N.Y. 10003. (212) 254-7410. Information clearinghouse for adoption in North America, particularly for children with special needs.

Families for Children, Inc., 10 Bowling Green, Pointe Clare 720, Quebec, Canada. International adoptions.

Holt Adoption Program, P.O. Box 2420, Eugene, OR 97402. International adoptions, primarily out of South Korea.

OURS (Organization for a United Response), 3148 Humboldt Avenue, South, Minneapolis, MN 55408. (612) 827-5709. Adoptive parent organization with broad experience in both in-country and international adoptions. Publishes an excellent bi-monthly newsletter.

CHILDFREE LIVING

National Organization for Nonparents, 806 Reistertown Road, Baltimore, MD 21208. Promotes and supports the decision to remain childfree.

INFERTILITY

AMEND, Dian Hoffman, 1548 Brenthaven, Floirisant, MO 63031. Organization for persons grieving the birth of imperfect or dead babies.

American Fertility Society, 1608-13th Avenue South, Suite 101, Birmingham, AL 35205. (205) 933-7222. Professional organization for doctors specializing in infertility. Names and addresses of members are available upon request.

The Barren Foundation, 6-East Monroe Street, Chicago, IL 60603. Provides brochures.

Planned Parenthood--World Population, 810 Seventh Avenue, New York, N.Y. 10019.

Resolve, Inc., P.O. Box 474, Belmont, MA 02178. (617) 484-2424. A national organization for the support of infertile persons through support groups, medical information and referral, and public education.

United Infertility, P.O. Box 23, Scarsdale, N.Y. 10583. Provides information.

SURROGATE PARENTING

Surrogate Parenting Associates, Inc., Suite 222, Doctors' Office Building, 250 East Liberty Street, Louisville, KY 40202. (502) 584-7794. Matches an infertile couple with a woman for the purpose of bearing a child for them through artificial insemination by the husband. Fees begin at $15,000 (1980) which include compensation for the surrogate mother as well as professional (medical and legal) fees. Complete anonymity is guaranteed for all parties involved.

FOOTNOTES

I. INTRODUCTION

1. Wayne Oates, Pastoral Care and Counseling in Grief and Separation (Philadelphia: Fortress Press, 1976), p. 1.

II. INFERTILITY IN THE OLD TESTAMENT

1. John Otwell, And Sarah Laughed (Philadelphia: Westminster Press, 1977), p. 49. He assumes these lists include only surviving children.

2. Raphael Patai, Sex and Family in the Bible and the Middle East (Garden City: Doubleday, 1959), p. 71.

3. The widow's "petition" was actually a ruse to convince King David to pardon and bring back his own son, Absalom. Cf. II Samuel 14:1-23.

4. The Hebrew word is banim, literally "sons," but would be used as a collective for sons and daughters. Thus, the verse may be translated either "Give me sons," or "Give me children."

5. The story of Hannah in I Samuel, and the Book of Job explicitly challenge this sin-punishment theology.

6. Phyllis Trible, God and the Rhetoric of Sexuality (Philadelphia: Fortress Press, 1978), p. 35.

7. Mandrakes are the root ot a potato-like plant, popular throughout the Mideast in ancient and modern times as a stimulant for conception. They were widely used in Europe during the Middle Ages.

8. John van Seters, "The Problem of Childlessness in near Eastern Law and the Patriarchs of Israel," Journal of Biblical Literature, LXXXVII (December 1968), 403.

9. Ibid., p. 406.

10. Ibid., pp. 401-408.

11. Patai, p. 78.

12. Ibid.

13. Ibid., p. 90.

14. Mary Chilton Callaway, "Sing, O Barren One: A Study in Comparative Midrash" (Unpublished doctoral dissertation, Columbia University, 1979), p. 154.

III. EARLY CHRISTIAN OPPOSITION TO THE FAMILY

1. United Methodist Church, The Book of Discipline (Nashville: United Methodist Publishing House, 1980), par. 71.

2. It is significant that the early church did not attribute such miracles to Jesus later. That it did not probably indicates that many of the Christian communities continued to de-emphasize the importance of producing children.

3. From a conversation with Bernadette Brooten, Visiting Professor in New Testament at the School of Theology at Claremont.

4. Jean-Jacques von Allmen, Pauline Teaching on Marriage (London: The Faith Press, 1963), p. 68.

5. Ibid.

6. Edgar Hennecke, New Testament Apocrypha, ed. R. McL. Wilson (Philadelphia: Westminster Press, 1976), pp. 323-324.

7. Ibid., p. 355.

8. Ibid., p. 356.

9. Ibid., p. 358.

10. Ibid., p. 364.

11. Elizabeth Clark, Jerome, Chrysostom, and Friends (New York: Mellen Press, 1979), p. 162.

12. Ibid., p. 158.

13. Ibid., p. 159.

14. Ibid., p. 9.

15. Ibid., p. 50.

16. Ibid.

IV. SOCIAL AND PHYSICAL ASPECTS

1. Mary Harrison, Infertility (Boston: Houghton Mifflin, 1977), p. 10.

2. Ibid., p. 34.

3. Ibid.

4. Ibid., p. 24.

5. Ibid., p. 25.

6. Ibid., p. 34.

7. Ibid., p. 26.

V. THE INFLUENCE OF PSYCHOLOGICAL FACTORS

1. Sheila Cheema, "An Investigation of the Relationship Between Anxiety, Attitude Toward Childbearing and Occurrence of Conception" (Doctoral Dissertation, New York University, 1974), pp. 12f.

2. Ibid., p. 13.

3. These dynamics apply to the husband also. Richardson's study focused on the infertile female, and so did not extend the discussion to personality and psychological problems contributing to infertility in the male, or to the male/female interacton.

4. Ivanna Martyniuk Richardson, "A Comparative Study of Personality Charateristics of Functionally Infertile and Fertile Women" (Doctoral Disseration, Texas Technical university, 1972), p. 3.

5. Ibid., pp. 4-6. Richardson, who reports Kroger's research, does not mention whether Kroger thought the dynamics would be the same if the husband had rejected the parenting role.

6. Ibid., p. 7.

7. The woman sometimes develops an immunity to her husband's sperm, and in some cases, a man may even develop antibodies to his own sperm. The degree to which this immunity might be affected by psychogenic factors has not been researched.

8. Richardson, p. 14.

9. Ibid.

10. Ibid., p. 18.

11. Ibid., p. 31.

12. Daniel Edward Dunne, "Psychological Factors Relating to Infertility of Couples and the Implications for Counseling and Psychotherapy" (Doctoral Dissertation, University of Southern

California, 1975), p. 16.

13. Ibid., p. 29.

14. Ibid.

15. Ibid., p. 154.

16. Ibid., p. 16.

17. Ibid.

18. Richardson, p. 56.

19. Richardson used the Personality Research Form (Form AA).

20. Richardson, p. 80.

21. Dunne, p. 26. Dunne cites Eisner (1963) and Carr (1963).

22. Ibid.

23. Herbert E. Walker, "Psychiatric Aspects of Infertility" Urologic Clinics of North America, V, 3 (October 1978), 484.

VI. THE ETHICAL ARGUMENTS: RAMSEY AND FLETCHER

1. Joseph Fletcher, The Ethics of Genetic Control (Garden City: Doubleday, 1974), p. 5.

2. This view, however, was not limited to Christian thinking, but seems to have been common in the philosophy of the time. Philo, the Jewish philosopher of Alexandria, had held this position three centuries before Augustine, so it clearly did not originate with this church father. See Jacob Neusner, Invitation to the Talmud (New York: Harper & Row, 1973), p. 3.

3. Fletcher, p. 15.

4. Ibid.

5. Eastman and Hellman, Williams' Obstetrics, p. 337. Cited in Fletcher, p. 15.

6. Paul Ramsey, Fabricated Man (New Haven: Yale University Press, 1970), p. 23.

7. Ibid., p. 23.

8. Ibid., p. 33.

9. Ibid., p. 39.

10. Ibid., p. 135.

11. Fletcher, p. 19.

12. Ibid., p. 81-82.

13. Ibid., p. 86.

14. Ibid., p. 87.

15. Ibid., p. 97.

16. Ibid., p. 91.

17. Ibid., p. 20.

VII. NARROWING ALTERNATIVES

1. Barbara Eck Menning, Infertility (Englewood Cliffs: Prentice-Hall, 1977), p. 147.

2. Ibid.

3. Ibid., p. 149.

4. Kaye Halverson, The Wedded Unmother (Minneapolis: Augsburg, 1980), p. 57.

5. Pat B. Anderson, "Social Agencies' Adoptions Decline," Los Angeles Times, December 20, 1979.

6. Menning, p. 146.

7. From a lecture by David and Ruth Kirk, "The Challenge of Change," quoted in Haverson, p. 56.

8. Halverson, p. 59.

9. Ibid., p. 63.

10. Menning, p. 143.

11. Ibid., p. 176.

12. Ibid., p. 146.

13. Quoted in Halverson, pp. 56f.

VIII. THE DYNAMICS OF CRISIS AND INFERTILITY

1. Sometimes couples seek medical help after they have been trying to get pregnant for only three or four months. Reassurance may be all that is needed, but, although it is too early for medical intervention, the couple should be seen as a couple who may be on the verge of--or in--a crisis. The fact that they have sought help indicates that they feel there is an important problem beyond their control. In this context, being told to go home and relax for another six months or so is not helpful.

2. Barbara Eck Menning, Infertility (Englewood Cliffs: Prentice-Hall, 1977), p. 53.

3. Gerald Caplan, cited in Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (Nashville: Abingdon Press, 1966), p. 160.

4. Ibid.

5. Erik H. Erikson, Identity and the Life Cycle (New York: International Universities Press, 1959), p. 97.

6. Ibid.

7. Howard W. Stone, Crisis Counseling (Philadelphia: Fortress Press, 1976), p. 7.

8. Kaye Haverson, The Wedded Unmother (Minneapolis: Augsburg, 1980), pp. 60-61.

9. Stone, p. 15.

10. Clinebell, p. 161.

11. Ibid.

12. Ibid., p. 164.

13. Ibid., p. 165.

IX. THE GRIEF EXPERIENCE

1. Quoted in David K. Switzer, The Dynamics of Grief (Nashville: Abingdon Press, 1970), p. 49.

2. The stages are those used in Elisabeth Kübler-Ross, On Death

and Dying (New York: Macmillan, 1969).

3. Boston Women's Health Book Collective, Our Bodies, Ourselves (New York: Simon and Schuster, 1976), p. 320.

4. William T. Bassett, Counseling the Childless Couple (Englewood Cliffs: Prentice-Hall, 1963), p. 64.

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